# EXHIBIT E

# United States Bankruptcy Court, District of New Jersey (Newark)

✓ Bed Bath & Beyond Inc.	Alamo Bed Bath & Beyond Inc.	BBB Canada LP Inc.	" BBB Value Services Inc.
(Case No. 23-13359)	(Case No. 23-13360)	(Case No. 23-13361)	(Case No. 23-13362)
BBBY Management Corporation	* BBBYCF LLC	~ BBBYTF LLC	bed 'n bath Stores Inc.
(Case No. 23-13363)	(Case No. 23-13364)	(Case No. 23-13365)	(Case No. 23-13396)
Bed Bath & Beyond of Annapolis, Inc. (Case No. 23-13366)	Bed Bath & Beyond of Arundel Inc. (Case No. 23-13367)	" Bed Bath & Beyond of Baton Rouge Inc. (Case No. 23-13368)	Bed Bath & Beyond of Birmingham Inc. (Case No. 23-13369)
Bed Bath & Beyond of Bridgewater Inc. (Case No. 23-13370)	Bed Bath & Beyond of California Limited Liability Company (Case No. 23-13371)	Bed Bath & Beyond of Davenport Inc. (Case No. 23-13372)	<ul><li>Bed Bath &amp; Beyond of East Hanove Inc.</li><li>(Case No. 23-13373)</li></ul>
Bed Bath & Beyond of Edgewater Inc. (Case No. 23-13374)	Bed Bath & Beyond of Falls Church, Inc. (Case No. 23-13375)	Bed Bath & Beyond of Fashion Center, Inc. (Case No. 23-13376)	Bed Bath & Beyond of Frederick, Inc. (Case No. 23-13377)
Bed Bath & Beyond of Gaithersburg Inc. (Case No. 23-13378)	Bed Bath & Beyond of Gallery Place L.L.C. (Case No. 23-13379)	Bed Bath & Beyond of Knoxville Inc. (Case No. 23-13380)	Bed Bath & Beyond of Lexington Inc. (Case No. 23-13381)
Bed Bath & Beyond of Lincoln Park Inc. (Case No. 23-13382)	Bed Bath & Beyond of Louisville Inc. (Case No. 23-13383)	Bed Bath & Beyond of Mandeville Inc. (Case No. 23-13384)	Bed, Bath & Beyond of Manhattan, In (Case No. 23-13397)
Bed Bath & Beyond of Opry Inc. (Case No. 23-13385)	Bed Bath & Beyond of Overland Park Inc. (Case No. 23-13386)	Bed Bath & Beyond of Palm Desert Inc. (Case No. 23-13387)	" Bed Bath & Beyond of Paradise Valley Inc. (Case No. 23-13388)
Bed Bath & Beyond of Pittsford Inc. (Case No. 23-13389)	Bed Bath & Beyond of Portland Inc. (Case No. 23-13390)	" Bed Bath & Beyond of Rockford Inc. (Case No. 23-13391)	Bed Bath & Beyond of Towson Inc. (Case No. 23-13392)
Bed Bath & Beyond of Virginia Beach Inc. (Case No. 23-13393)	Bed Bath & Beyond of Waldorf Inc. (Case No. 23-13394)	Bed Bath & Beyond of Woodbridge Inc. (Case No. 23-13395)	" Buy Buy Baby of Rockville, Inc. (Case No. 23-13398)
Buy Buy Baby of Totowa, Inc. (Case No. 23-13399)	Buy Buy Baby, Inc. (Case No. 23-13400)	<sup>~</sup> BWAO LLC (Case No. 23-13401)	Chef C Holdings LLC (Case No. 23-13402)
Decorist, LLC (Case No. 23-13403)	Deerbrook Bed Bath & Beyond Inc. (Case No. 23-13404)	Harmon of Brentwood, Inc. (Case No. 23-13405)	Harmon of Caldwell, Inc. (Case No. 23-13406)
Harmon of Carlstadt, Inc. (Case No. 23-13407)	Harmon of Franklin, Inc. (Case No. 23-13408)	Harmon of Greenbrook II, Inc. (Case No. 23-13409)	Harmon of Hackensack, Inc. (Case No. 23-13410)
Harmon of Hanover, Inc. (Case No. 23-13411)	Harmon of Hartsdale, Inc. (Case No. 23-13412)	Harmon of Manalapan, Inc. (Case No. 23-13413)	Harmon of Massapequa, Inc. (Case No. 23-13414)
Harmon of Melville, Inc. (Case No. 23-13415)	Harmon of New Rochelle, Inc. (Case No. 23-13416)	Harmon of Newton, Inc. (Case No. 23-13417)	" Harmon of Old Bridge, Inc. (Case No. 23-13418)
Harmon of Plainview, Inc. (Case No. 23-13419)	Harmon of Raritan, Inc. (Case No. 23-13420)	Harmon of Rockaway, Inc. (Case No. 23-13421)	" Harmon of Shrewsbury, Inc. (Case No. 23-13422)
Harmon of Totowa, Inc. (Case No. 23-13423)	Harmon of Wayne, Inc. (Case No. 23-13424)	Harmon of Westfield, Inc. (Case No. 23-13425)	Harmon of Yonkers, Inc. (Case No. 23-13426)
Harmon Stores, Inc. (Case No. 23-13427)	Liberty Procurement Co. Inc. (Case No. 23-13428)	~ Of a Kind, Inc. (Case No. 23-13429)	One Kings Lane LLC (Case No. 23-13430)
San Antonio Bed Bath & Beyond Inc. (Case No. 23-13431)	~ Springfield Buy Buy Baby, Inc. (Case No. 23-13432)		J

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# Modified Official Form 410

# **Proof of Claim**

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.

P	art 1: Identify the Cla	aim								
1.	Who is the current creditor?	Carla Cox Smith								
		Name of the current creditor (the person or entity to be paid for this cla	im)							
		Other names the creditor used with the debtor								
2.	Has this claim been acquired from someone else?	✓ No Yes. From whom?								
3.	and payments to the	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)							
	creditor be sent?	7777 Bonhomme Ave #2100								
	Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	St. Louis, MO 63105								
		Contact phone 314-863-0500	Contact phone							
		Contact email ben@missourilawyers.com	Contact email							
4.	Does this claim amend one already filed?	✓ No Yes. Claim number on court claims registry (ifknown)	Filed on							
5.	Do you know if anyone else has filed a proof of claim for this claim?	✓ No Yes. Who made the earlier filling?								
	Part 2: Give Informat	tion About the Claim as of the Date the Case Was F	iled							
6.	Do you have any number you use to identify the debtor?	✓ No Yes. Last 4 digits of the debtor's account or any number	you use to identify the debtor:							
7.	How much is the claim?	\$no less than 1,000,000.00. Does this amoun	t include interest or other charges?							
		Yes. Attach st	atement itemizing interest, fees, expenses, or other required by Bankruptcy Rule 3001(c)(2)(A).							
3. 1	What is the basis of the	Examples: Goods sold, money loaned, lease, services perfo	ormed, personal injury or wrongful death, or creditcard.							
	claim?	Attach redacted copies of any documents supporting the cla	im required by Bankruptcy Rule 3001(c).							
		Limit disclosing information that is entitled to privacy, such a	s health care information.							
		Personal injury (unliquidated)								
		Proof of Claim	nage 2							

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9. Is all or part of the claim secured?	✓ No Yes. The claim is secured by a lien on property.  Nature of property:  Real estate. If the claim is secured by the debtor's principal residence, file a Mort.	gage Proof of Claim
	Attachment (Official Form 410-A) with this Proof of Claim.  Motor vehicle Other. Describe:	
	Basis for perfection:  Attach redacted copies of documents, if any, that show evidence of perfection of a see example, a mortgage, lien, certificate of title, financing statement, or other document been filed or recorded.)	
	Value of property: \$	
	Amount of the claim that is secured: \$	
	Amount of the claim that is unsecured: \$(The sum of the s amounts should r	ecured and unsecured match the amount in line 7.)
	Amount necessary to cure any default as of the date of the petition: \$	
	Annual Interest Rate (when case was filed)%  Fixed  Variable	
10. Is this claim based on a lease?	✓ No  Yes. Amount necessary to cure any default as of the date of the petition.  \$	
11. Is this claim subject to a right of setoff?	✓ No Yes. Identify the property:	
12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?	✓ No Yes. Check one:	Amount entitled to priority
A claim may be partly priority and partly nonpriority. For example,	Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$
in some categories, the law limits the amount entitled to priority.	Up to \$3,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$
	Wages, salaries, or commissions (up to \$15,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	\$
	Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$
	Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$
	Other. Specify subsection of 11 U.S.C. § 507(a)( ) that applies.	\$
	* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for cases begun on or after	the date of adjustment.

Proof of Claim page 3

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13. Is all or part of the claim entitled to administrative priority pursuant to 11 U.S.C. § 503(b)(9)?	by the Debt which the g Debtor's bu	e the amount of your claim arising from the value o or within 20 days before the date of commencemen oods have been sold to the Debtor in the ordinary c siness. Attach documentation supporting such clai	t of the above case, in course of such	\$
14. Is all or part of the claim being asserted as an administrative expense claim?	the estates	e the amount of your claim for costs and expenses pursuant to 503(b), other than section 503(b)(9), or tion supporting such claim. If yes, please indicate v	507(a)(2). Attach	
**************************************		On or prior to June 27, 2023:		\$
		☐ After June 27, 2023:		\$
		Total Administrative Expense Claim Amount:		\$
ABOVE DEBTORS FOR POOR A KIND ENTITLED TO POOR SHOULD NOT BE USED FO	STPETITION ADM	CLAIMANTS ASSERTING AN ADMINISTRATIVE EX MINISTRATIVE CLAIMS. THIS SECTION SHOULD NO ORDANCE WITH 11 U.S.C. §§ 503(B) AND 507(A)(2); UANT TO SECTION 503(B)(9) OF THE BANKRUPTC	OT BE USED FOR ANY PROVIDED, HOWEVE	CLAIMS THAT ARE NOT
Part 3: Sign Below		\$4.75 km - 1		
The person completing this proof of claim must sign and date it. FRBP 9011(b).  If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.  A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both.  18 U.S.C. §§ 152, 157, and 3571.	I am the tru I am a guar I understand tha amount of the cl. I have examined and correct. I declare under p Executed on dat  /s/ Ben S Signature	editor.  editor's attorney or authorized agent.  stee, or the debtor, or their authorized agent. Bankruptor antor, surety, endorser, or other codebtor. Bankruptor is an authorized signature on this <i>Proof of Claim</i> serves aim, the creditor gave the debtor credit for any payment is the information in this <i>Proof of Claim</i> and have a reason penalty of perjury that the foregoing is true and correct.  e 12/29/2023  MM / DD / YYYYY	Rule 3005. as an acknowledgment ts received toward the de	ebt.
	Ivaille	First name Middle name	Last name	
	Title	Attorney		
	Company	Sansone and Lauber		
		Identify the corporate servicer as the company if the authoriz	zed agent is a servicer.	
	Address	City	MO State ZIP Code	
	Contact phone	314-863-0500	<sub>Email</sub> ben@ <u>missouril</u>	awyers.com

Proof of Claim page 4

# Modified Official Form 410

# **Instructions for Proof of Claim**

United States Bankruptcy Court

12/15

These instructions and definitions generally explain the law. In certain circumstances, such as bankruptcy cases that debtors do not file voluntarily, exceptions to these general rules may apply. You should consider obtaining the advice of an attorney, especially if you are unfamiliar with the bankruptcy process and privacy regulations.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. \$\$ 152, 157 and 3571.

# How to fill out this form

- Fill in all of the information about the claim as of the date the case was filed.
- Fill in the caption at the top of the form.
- If the claim has been acquired from someone else, then state the identity of the last party who owned the claim or was the holder of the claim and who transferred it to you before the initial claim was filed.
- Attach any supporting documents to this form.

Attach redacted copies of any documents that show that the debt exists, a lien secures the debt, or both. (See the definition of *redaction* on the next page.)

Also attach redacted copies of any documents that show perfection of any security interest or any assignments or transfers of the debt. In addition to the documents, a summary may be added. Federal Rule of Bankruptcy Procedure (called "Bankruptcy Rule") 3001(c) and (d).

- Do not attach original documents because attachments may be destroyed after scanning.
- If the claim is based on delivering health care goods or services, do not disclose confidential health care information. Leave out or redact confidential information both in the claim and in the attached documents.

- A Proof of Claim form and any attached documents must show only the last 4 digits of any social security number, individual's tax identification number, or financial account number, and only the year of any person's date of birth. See Bankruptcy Rule 9037.
- For a minor child, fill in only the child's initials and the full name and address of the child's parent or guardian. For example, write A.B., a minor child (John Doe, parent, 123 Main St., City, State). See Bankruptcy Rule 9037.

# Confirmation that the claim has been filed

To receive confirmation that the claim has been filed, enclose a stamped self-addressed envelope and a copy of this form. You may view a list of filed claims in this case by visiting the Claims and Noticing Agent's website at <a href="https://restructuring.ra.kroll.com/BBBY">https://restructuring.ra.kroll.com/BBBY</a>.

# Understand the terms used in this form

**Administrative expense:** Generally, an expense that arises after a bankruptcy case is filed in connection with operating, liquidating, or distributing the bankruptcy estate. 11 U.S.C. § 503.

**Claim:** A creditor's right to receive payment for a debt that the debtor owed on the date the debtor filed for bankruptcy. 11 U.S.C. §101 (5). A claim may be secured or unsecured.

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Claim Pursuant to 11 U.S.C. §503(b)(9): A claim arising from the value of any goods received by the Debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of the Debtor's business. Attach documentation supporting such claim.

**Creditor:** A person, corporation, or other entity to whom a debtor owes a debt that was incurred on or before the date the debtor filed for bankruptcy. 11 U.S.C. §101 (10).

**Debtor:** A person, corporation, or other entity who is in bankruptcy. Use the debtor's name and case number as shown in the bankruptcy notice you received. 11 U.S.C. § 101(13).

**Evidence of perfection:** Evidence of perfection of a security interest may include documents showing that a security interest has been filed or recorded, such as a mortgage, lien, certificate of title, or financing statement.

Information that is entitled to privacy: A *Proof of Claim* form and any attached documents must show only the last 4 digits of any social security number, an individual's tax identification number, or a financial account number, only the initials of a minor's name, and only the year of any person's date of birth. If a claim is based on delivering health care goods or services, limit the disclosure of the goods or services to avoid embarrassment or disclosure of confidential health care information. You may later be required to give more information if the trustee or someone else in interest objects to the claim.

Priority claim: A claim within a category of unsecured claims that is entitled to priority under 11 U.S.C. §507(a). These claims are paid from the available money or property in a bankruptcy case before other unsecured claims are paid. Common priority unsecured claims include alimony, child support, taxes, and certain unpaid wages.

**Proof of claim:** A form that shows the amount of debt the debtor owed to a creditor on the date of the bankruptcy filing. The form must be filed in the district where the case is pending.

**Redaction of information:** Masking, editing out, or deleting certain information to protect privacy. Filers must redact or leave out information entitled to **privacy** on the *Proof of Claim* form and any attached documents.

Secured claim under 11 U.S.C. §506(a): A claim backed by a lien on particular property of the debtor. A claim is secured to the extent that a creditor has the right to be paid from the property before other creditors are paid. The amount of a secured claim usually cannot be more than the value of the particular property on which the creditor has a lien. Any amount owed to a creditor that is more than the value of the property normally may be an unsecured claim. But exceptions exist; for example, see 11 U.S.C. § 1322(b) and the final sentence of 1325(a).

Examples of liens on property include a mortgage on real estate or a security interest in a car. A lien may be voluntarily granted by a debtor or may be obtained through a court proceeding. In some states, a court judgment may be a lien.

**Setoff:** Occurs when a creditor pays itself with money belonging to the debtor that it is holding, or by canceling a debt it owes to the debtor.

**Unsecured claim:** A claim that does not meet the requirements of a secured claim. A claim may be unsecured in part to the extent that the amount of the claim is more than the value of the property on which a creditor has a lien.

# Offers to purchase a claim

Certain entities purchase claims for an amount that is less than the face value of the claims. These entities may contact creditors offering to purchase their claims. Some written communications from these entities may easily be confused with official court documentation or communications from the debtor. These entities do not represent the bankruptcy court, the bankruptcy trustee, or the debtor. A creditor has no obligation to sell its claim. However, if a creditor decides to sell its claim, any transfer of that claim is subject to Bankruptcy Rule 3001(e), any provisions of the Bankruptcy Code (11 U.S.C. § 101 et seq.) that apply, and any orders of the bankruptcy court that apply.

# Please send completed Proof(s) of Claim to:

If by first class mail:

Bed Bath & Beyond Inc. Claims Processing Center c/o Kroll Restructuring Administration LLC Grand Central Station, PO Box 4850 New York, NY 10163

If by overnight courier or hand delivery:

Bed Bath & Beyond Inc. Claims Processing Center c/o Kroll Restructuring Administration LLC 850 3rd Avenue, Suite 412 Brooklyn, NY 11232

You may also file your claim electronically at https://restructuring.ra.kroll.com/BBBY/EPOC-Index.

Do not file these instructions with your form

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# ADVANCED INJURY CARE

8225 Clayton Road, Saint Louis, MO 631171107

**Post Op Follow Up Note** 

# **CARLA COX SMITH**

MRN:

Birthday:

Phone:

Visited on: 2023 Aug 03 15:00 (Age at visit: 63 years)

Electronically signed by: GEORGE PALETTA, M.D. on 2023-08-17 09:02

HPI

HPI

Carla returns today for an initial postop visit status post revision rotator cuff repair. At the time of surgery, the bulk of her previous repair had healed. She had a retear at the edge of the repair at one of the anchor sites that extended for about a centimeter or so. She returns today for follow up stating she is doing well. She denies any wound drainage or fevers. She's been compliant with the sling and abduction pillow. She states overall her pain control has been good.

**EXAM** 

Examination of the left shoulder reveals surgical incisions to be well healed. No sign of infection. Forward elevation is to 90. External rotation is to neutral. Internal and external rotation activation is good. Deltoid fires nicely. Neurovascular status is intact.

RESULTS

No radiographs obtained today.

**IMPRESSION** 

Doing well.

**PLAN** 

I reviewed with her the findings at the time of surgery. Given the fact this is a revision, we will hold off on starting physical therapy until after the fourth week. As such, she will not start therapy until the week of 8-14-23. She will remain in the sling for a total of six weeks but she does not require the abduction pillow. She can come out of the sling for light activities such as self-care, keyboarding and utensils to eat. We will see her back for follow up in four weeks. X-rays at that time include a left shoulder series. Expectation is she should be ready to discontinue the sling.

George A. Paletta, Jr., M.D.

GAP:kh

This report was dictated by George A. Paletta, Jr. and approved without proofreading/ editing to expedite distribution.

Printed on: 2023 Aug 17 09:41 Note created using Kareo

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# ADVANCED INJURY CARE

8225 Clayton Road, Saint Louis, MO 631171107

**Post Op Follow Up Note** 

# **CARLA COX SMITH**

MRN:

Birthday:

Visited on: 2023 Sep 14 13:30 (Age at visit: 63 years)

Phone:

Electronically signed by: GEORGE PALETTA, M.D. on 2023-09-18 08:58

# HPI

Carla returns today for continued follow up of her left shoulder. She is status post an initial rotator cuff repair that was performed in February 2023. She was progressing nicely from that but unfortunately was involved in a second motor vehicle accident that resulted in recurrent left shoulder pain and evidence of a recurrent rotator cuff tear. This precipitated a second surgery including arthroscopy of the left shoulder with revision rotator cuff repair. That surgery was performed on July 17, 2023. She returns for follow up today.

Overall, she is doing well. She is very pleased with her progression of range of motion. She is really having minimal pain at this point. She has been doing her physical therapy at Athletico. An update from the therapist documents excellent compliance and good range of motion. The patient is pleased with her progress.

With respect to her neck, she has continued with chiropractic treatment at this point. There were some discussions with regard to interventions at the cervical spine, but she has preferred to continue to go the chiropractic route and reports overall things are doing okay with regard to the neck.

# **EXAM**

Examination of the left shoulder reveals surgical incisions to be well healed. Range of motion is outstanding. She has full forward elevation to 170. Abduction is to 160. She has no residual shoulder shrug. 30 degrees of rotation with the arm at the side. Her cuff is firing nicely. Internal and external rotation strength are 5-/5. Supraspinatus strength was not assessed but she sets her shoulder nicely with no shoulder shrug and no pain.

# **RESULTS**

No radigraphs taken today.

# **IMPRESSION**

1. Doing well.

# **PLAN**

She has met and exceeded all the goals and milestones of the first phase of therapy. She will now progress to Phase 2 working on progressive rotator cuff strengthening. The plan is to see her back for follow up in about six to eight weeks, whatever works for her schedule and mine. At that point, I would anticipate she will likely be done with physical therapy and ready to go to a home exercise program. Obviously, she should continue treatment for her cervical spine based on the recommendations of those providers. I addressed her questions.

George A. Paletta, Jr., M.D.

GAP: sdm

This report was dictated by#George A. Paletta, Jr.#and approved without proofreading/editing to expedite distribution.

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# ADVANCED INJURY CARE

8225 Clayton Road, Saint Louis, MO 631171107

**Post Op Follow Up Note** 

# **CARLA COX SMITH**

MRN:

Birthday:

Phone:

Visited on: 2023 Nov 09 13:30 (Age at visit: 64 years)

Electronically signed by: GEORGE PALETTA, M.D. on 2023-11-13 02:34

# HPI

Carla returns today for continued follow up of her left shoulder. She is status post initial rotator cuff repair performed on 2-13-23. She was doing well in her course of recovery but then unfortunately was involved in a second motor vehicle accident that resulted in recurrent and increasing left shoulder pain. She underwent an evaluation at that time which showed evidence of a recurrent rotator cuff tear requiring revision surgery.

The revision surgery was performed on 7-18-23. She returns today for follow up stating overall she is doing well. She still notes some occasional discomfort at night. She has been progressing with physical therapy. She feels like she's done so much therapy at this point that she can do most of it on her own. Overall, she feels like it continues to improve steadily.

# **EXAM**

Examination of the left shoulder reveals outstanding motion. She has full forward elevation and abduction to 170 with normal kinematics. She has restored full rotational range of motion including external rotation at the side as well as in the 90/90 position. She has good cuff function. Internal and external rotation strength are 5/5. Supraspinatus strength is 5-/5 with no residual shoulder shrug and minimal discomfort on resisted manual testing. Impingement signs are negative.

# RESULTS

No radiographs obtained today.

# **IMPRESSION**

Mild residual supraspinatus weakness status post revision rotator cuff repair.

# **PLAN**

In my opinion, Carla can back off to once a week for physical therapy for the next three or four weeks and transition to a home exercise program thereafter. In my opinion, she requires no specific restrictions or limitations at this point. Obviously, anything that causes discomfort in the shoulder she should avoid or back off on. I would like to see her back for follow up in eight weeks. At that point she'll be about a month into a home exercise program. If she's doing well, she'll be released from care at that point. I addressed her questions.

George A. Paletta, Jr., M.D.

GAP:kh

This report was dictated by #George A. Paletta, Jr. #and approved without proofreading/ editing to expedite distribution.

Printed on: 2023 Nov 14 09:07 Note created using Kareo

Rendering: Gillette PT, DPT, Sara Location: Florissant Location Phone: (314)972-1442 Location Fax: (314)972-1533



PHYSICAL THERAPY

Patient: Cox Smith, Carla

DOB: 02/20/2022 10:20 AM

**DOS:** 03/29/2023 10:30 AM

Ref Phys: George Paletta Jr MD

Person #: 1283611
Attended Appointments: 7
Cancelled Appointments: 1

Payer: Lien

Ref Phys Fax: (314) 336-2639

CC:

Case Contacts:

Name	Phone	Fax	Email
Paletta Jr MD, George	(314) 336-2555	(314) 658-9684	
Ben Sansone	(314) 863-0503		heather@missourilawyers.com

# Diagnosis:

Strain of musc/tend the rotator cuff of left shoulder, subs S46.012D Encounter for other orthopedic aftercare Z47.89

Dear George Paletta Jr MD,

Thank you for your referral of Carla Cox Smith to Athletico's center in Florissant.

# Assessment:

Patient was re-educated on not using UE per MD protocol and the risks of not following MD orders. Patient has been told one multiple occasions to not use her UE to lift, throw, push or pull. Patient states, "wow, I didn't realize how serious it is. But I can tell by your tone of voice that it is... thank you for re-iterating it to me." Patient is just over 6 weeks, plan to progress into early strengthening phase (6-14 weeks post-op).

# Subjective:

Patient reports she is feeling fine. She states she missed therapy yesterday due to dealing with family issues.

### Objective:

Patient is observed to hold her arm up in the air in a supine position. Patient is observed to toss swiss ball with B UE after doing wall slides. Full PROM.

### Goals:

Short Term Goals	Status	Type	Achieved
Patient will be able to reach to shoulder height shelf by 5/1/2023.	In Progress	STG	
Long Term Goals	Status	Type	Achieved
Patient will be able to reach OH shelf by 6/1/2023.	In Progress	LTG	
Patient will be able to reach behind her back to tuck in her shirt by	In Progress	LTG	
6/1/2023.			
Patient will be able to carry 5 lbs unilaterally to improve her ability to	In Progress	LTG	
carry groceries by 6/1/2023.			

# Plan:

Plan to progress with gentle shoulder AROM and rotator cuff strength at modified neutral.

Thank you, again, for the referral of Carla Cox Smith to Athletico's center in Florissant. Please feel free to contact me with any questions at (314)972-1442.

Person #: 1283611 Cox Smith, Carla DOS: 03/29/2023 10:30 AM Page 1 of 2

Case 23-13359-VFP Doc 2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Desc Exhibit E Page 12 of 45
Rendering: Gillette PT, DPT, Sara Location: Florissant Location Phone: (314)972-1442 Location Fax: (314)972-1533

Sincerely,

Electronically signed by Sara Gillette PT, DPT on 03/30/2023 02:58 PM

Page 2 of 2 Person #: 1283611 Cox Smith, Carla DOS: 03/29/2023 10:30 AM

STATE OF MISSOURI

COUNTY OF ST. LOUIS

AFFIDAVIT AS TO BILLING RECORDS, RESONABLENESS OF MEDICAL CHARGES AND NECESSITY OF TREATMENT
Before me, the undersigned authority, personally appeared
My name is
I am the custodian of records and designee of the entity who provided services to the patient named below.
Attached to this Affidavit is page(s) of billing records reflecting services and charges by ADVANCED INJURY CARE to to cor cor, date of birth These records were kept in the regular course of business and the records were made at or near the time the services and charges were rendered. The amounts charged for the itemized services were reasonable at the time and place the services were provided.
ADVANCED INJURY CARE deemed the services necessary to treat (a la (ux fm 1 ) + AFFIANT
In witness whereof, I have hereunto subscribed my name and affixed my official seal, this 3 day of
(SEAL) Clerc Panes Notary Public
My Term Expires:  CELENA PARRES Notary Public - Notary, Seal St Charles County - State of Missouri Commission Number 21775831 My Commission Expires Aug 4, 2025

ADVANCED INJURY CARE

# **Itemization of Charges**

For Posting Date March 31, 2023

ADVANCED INJURY CARE Clinic:

Address:

8225 Clayton Road Saint Louis, MO 631171107 Sansone & Lauber Insurance #1: 7777 BONHOMME AVE #2100 SAINT LOUIS, MO 63105

Phone: (314) 330-4776 Adjuster: Tax ID: 822699429 **Group Number** 

WCAB: **Policy Number:** 0

Insurance #2: Employer:

Patient #: 7569 Adjuster:

Carla Cox SMITH **Group Number:** Patient:

Date of Injury: **Policy Number:** 

Visit#	Service Date	Provider Name	Procedure Description	Code	Charges	Adjust	Payments	Balance
16621	06/13/2022	LINDSEY PATERSON, PA-C	New patient office or othe	99204	1,100.00	-	-	1,100.00
17442	07/06/2022	SAMUEL BARTMESS, M.D.	Injection of substance int	62321	2,815.24	-	-	2,815.24
17442	07/06/2022	SAMUEL BARTMESS, M.D.	Lidocaine level	80176	100.00	-	-	100.00
17442	07/06/2022	SAMUEL BARTMESS, M.D.	Surgical trays	A4550	500.00	-	-	500.00
17442	07/06/2022	SAMUEL BARTMESS, M.D.	Injection, dexamethasone s	J1100	350.00	-	-	350.00
17442	07/06/2022	SAMUEL BARTMESS, M.D.	Low osmolar contrast mater	Q9966	500.00	-	-	500.00
17523	07/06/2022	STEVEN STAHLE, M.D.	Established patient office	99213	550.00	-	-	550.00
18058	07/20/2022	KORRIN TILLEY, PA	Established patient office	99213	550.00	-	-	550.00
19022	08/09/2022	LINDSEY PATERSON, PA-C	Established patient office	99213	550.00	-	-	550.00
19294	08/09/2022	SAMUEL BARTMESS, M.D.	Injection of anesthetic an	64483	2,658.37	-	-	2,658.37
19294	08/09/2022	SAMUEL BARTMESS, M.D.	Lidocaine level	80176	100.00	-	-	100.00
19294	08/09/2022	SAMUEL BARTMESS, M.D.	Surgical trays	A4550	500.00	-	-	500.00
19294	08/09/2022	SAMUEL BARTMESS, M.D.	Injection, dexamethasone s	J1100	350.00	-	-	350.00
19294	08/09/2022	SAMUEL BARTMESS, M.D.	Low osmolar contrast mater	Q9966	500.00	-	-	500.00
19919	08/24/2022	NICOLE HELLWEG, PA- CMPAS	Established patient office	99213	550.00	-	-	550.00
20028	08/24/2022	SAMUEL BARTMESS, M.D.	Injection of upper or midd	64490	3,274.98	-	-	3,274.98
20028	08/24/2022	SAMUEL BARTMESS, M.D.	Injection of upper or midd	64491	1,554.00	-	-	1,554.00
20028	08/24/2022	SAMUEL BARTMESS, M.D.	Lidocaine level	80176	100.00	-	-	100.00
20028	08/24/2022	SAMUEL BARTMESS, M.D.	Surgical trays	A4550	500.00	-	-	500.00
20140	08/30/2022	SAMUEL BARTMESS, M.D.	Injection of upper or midd	64490	3,274.98	-	-	3,274.98
20140	08/30/2022	SAMUEL BARTMESS, M.D.	Injection of upper or midd	64491	1,554.00	-	-	1,554.00
20140	08/30/2022	SAMUEL BARTMESS, M.D.	Lidocaine level	80176	100.00	-	-	100.00
20140	08/30/2022	SAMUEL BARTMESS, M.D.	Established patient office	99213	550.00	-	-	550.00

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# Case 23-13359-VFP Doc 2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Desc Exhibit E Page 15 of 45

ADVANCED INJURY CARE

# **Itemization of Charges**

For Posting Date March 31, 2023

20140	08/30/2022	SAMUEL BARTMESS, M.D.	Surgical trays	A4550	500.00	-	-	500.00
20418	09/08/2022	SAMUEL BARTMESS, M.D.	Destruction of upper or mi	64633	17,000.00	-	-	17,000.00
20418	09/08/2022	SAMUEL BARTMESS, M.D.	Destruction of upper or mi	64634	8,000.00	-	-	8,000.00
20418	09/08/2022	SAMUEL BARTMESS, M.D.	Lidocaine level	80176	100.00	-	-	100.00
20418	09/08/2022	SAMUEL BARTMESS, M.D.	Established patient office	99213	550.00	-	-	550.00
20418	09/08/2022	SAMUEL BARTMESS, M.D.	Surgical trays	A4550	500.00	-	-	500.00
21457	09/22/2022	LINDSEY PATERSON, PA-C	Established patient office	99213	550.00	-	-	550.00
24170	11/01/2022	LINDSEY PATERSON, PA-C	Established patient office	99213	550.00	-	-	550.00
24060	11/07/2022	KALEN VESPOLI, M.D., AP	Established patient office	99213	550.00	-	-	550.00
26476	12/15/2022	GEORGE PALETTA, M.D.	X-ray of shoulder, minimum	73030	250.00	-	-	250.00
26476	12/15/2022	GEORGE PALETTA, M.D.	New patient office or othe	99204	1,250.00	-	-	1,250.00
31972	02/13/2023	GEORGE PALETTA, M.D.	Incision of shoulder tendo	23405	12,951.85	-	-	12,951.85
31972	02/13/2023	GEORGE PALETTA, M.D.	Manipulation of shoulder j	23700	2,554.86	-	-	2,554.86
31972	02/13/2023	GEORGE PALETTA, M.D.	Limited removal of abnorma	29822	15,425.00	-	-	15,425.00
31972	02/13/2023	GEORGE PALETTA, M.D.	Shaving of part of shoulde	29826	15,702.80	-	-	15,702.80
31972	02/13/2023	GEORGE PALETTA, M.D.	Repair of shoulder rotator	29827	21,138.00	-	-	21,138.00
31972	02/13/2023	GEORGE PALETTA, M.D.	Cold or hot fluid bottle,	A9273	75.00	-	-	75.00
31972	02/13/2023	GEORGE PALETTA, M.D.	Fluid circulating cold pad	E0218	675.00	-	-	675.00
31972	02/13/2023	GEORGE PALETTA, M.D.	Shoulder orthosis, acromio	L3670	250.00	-	-	250.00
30597	02/23/2023	GEORGE PALETTA, M.D.	Follow-up visit after surg	99024	-	-	-	-
TOTALS					121,154.08	-	-	

**BALANCE DUE** 121,154.08

3/31/2023 8:02:52 AM Page 2 of 2



PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/-		PICA
1. MEDICARE MEDICAID TRICARE CHAM	DEALTH DLAN DIVILING	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) (Medicaid#) (ID#/DoD#) (Membe	(ID#) (ID#) (ID#) (ID#) (ID#)	0
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
COX SMITH, CARLA	M F X	COX SMITH, CARLA
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1018 TRIFECTA DR	Self X Spouse Child Other	1018 TRIFECTA DR
CITY STAT	8. RESERVED FOR NUCC USE	CITY STATE
FLORISSANT		FLORISSANT MO
ZIP CODE TELEPHONE (Include Area Code)	7	ZIP CODE TELEPHONE (Include Area Code)
53034 ( )-		63034 ( )-
D. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
	YES X NO	MM DD YY M FX
D. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	SANSONE & LAUBER
J. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	(200g) (dod 0) (1000)	YES X NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLET	NG & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE   authorize to process this claim. I also request payment of government benefits eith</li> </ol>	e release of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier
to process this claim. I also request payment or government benefits eith below.	to mysell of to the party who accepts assignment	services described below.
SIGNED Signature on File	DATE 03/31/23	   <sub>SIGNED</sub> Signature on File
		-
MM   DD   YY	5. OTHER DATE UAL.   MM   DD   YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD TO
QOAL.		
	7a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD DD TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	7b. NPI	FROM TO  20. OUTSIDE LAB? \$ CHARGES
18. ADDITIONAL CLAIM INFORMATION (Designated by NOCC)		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to so	nice line helew (245)	YES X NO
	ICD Ind. 0	22. RESUBMISSION ORIGINAL REF. NO.
A. [ <b>W230XXA</b> B. [ C.	D	ON PRIOR AUTHORIZATION NUMBER
E F G.	L н. L	23. PRIOR AUTHORIZATION NUMBER
I J K.	L. L.	
	CEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS	F. G. H. I. J. DAYS EPSDI ID. RENDERING OR Family
MM DD YY MM DD YY SERVICE EMG CPT/H	PCS   MODIFIER POINTER	\$ CHARGES UNITS Plan QUAL. PROVIDER ID. #
06   13   22   06   13   22   11   992	)4	1100 00 1 NPI 1912584509
		NPI
		NPI
		NPI NPI
		NPI
		NPI NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUC
322699429		\$ 1100 00 \$ 0 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE	FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (314) 330-4776
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		ADVANCED INJURY CARE
apply to this bill and are made a part thereof.) 8225 CI	AYTON ROAD	8225 CLAYTON ROAD
<b>-</b>	OUIS, MO 63117-1107	SAINT LOUIS, MO 63117-1107
LINDSEY S PATERSON, PA-	DI b.	a. NDI b.
SIGNED $03/31/23$ DATE $a$ .		- INF



APPROVED BY NATIONAL UNIFO	RM CLAIM COM	MMITTEE (N	UCC) 02/12											PICA
1. MEDICARE MEDICAID	TRICAR	_	CHAMPV	- HEA	LTH PLAN 🗕	FECA BLK LUN	C	1a. INSURED'S	I.D. NU	JMBER			(For Progra	am in Item 1)
(Medicare#) (Medicaid#)  2. PATIENT'S NAME (Last Name,		357 <u> </u>	(Member ID	3. PATIENT		(ID#) TE	X (ID#)	4. INSURED'S N	JAME (	Last Name	e. First	Name.	Middle Initial)	
COX SMITH, CAR		adio miliary		MM	אלי אלו	м	F X	COX SM					madic irilai)	
5. PATIENT'S ADDRESS (No., St	eet)			6. PATIENT	RELATIONS	HIP TO INS	URED	7. INSURED'S A	DDRE	SS (No., S	Street)			
1018 TRIFECTA	DR		,		Spouse	Child	Other	1018 TE	RIF	ECTA	DR			
CITY			MO	8. RESERVI	ED FOR NUC	CC USE		CITY	יזא אי	т				MO STATE
FLORISSANT ZIP CODE	TELEPHONE (I	Include Area	1					FLORISS	OAIN.	1	TEL	EPHONE	E (Include Are	1
63034	( )-		,					63034				(	) -	5555)
9. OTHER INSURED'S NAME (La	st Name, First N	lame, Middle	Initial)	10. IS PATIE	ENT'S COND	ITION RELA	TED TO:	11. INSURED'S	POLIC	Y GROUP	ORF	ECA NU	JMBER	
a. OTHER INSURED'S POLICY C	R GROUP NUM	MBER		a. EMPLOYI	MENT? (Curi	ent or Previo	ous)	a. INSURED'S E	DATE C	F BIRTH	_		SEX	
DECERVED FOR MUCO HOE					YES	X NO						М		F X
b. RESERVED FOR NUCC USE				b. AUTO AC			PLACE (State)	b. OTHER CLAI	M ID (	Designated	by N	UCC)		
c. RESERVED FOR NUCC USE				c. OTHER A	CCIDENT?	X NO		c. INSURANCE	PI AN I	NAME OF	PRO	SRAM N	IAME	
S LOCATED A STATEOUT OF				S. GIIILIIA	YES	X NO	i	SANSONE					VIL	
d. INSURANCE PLAN NAME OR	PROGRAM NAM	ME		10d. CLAIM	CODES (De			d. IS THERE AN					AN?	
								YES	X	NO	If yes,	complet	te items 9, 9a	, and 9d.
READ I  12. PATIENT'S OR AUTHORIZED  to process this claim. I also required below.		SNATURE 18	authorize the r	elease of any	medical or ot	her information		13. INSURED'S payment of n services des	nedical	benefits to				I authorize or supplier fo
SIGNED Signature	on Fi	le		DA	TE 03/	31/23		SIGNED	Sig	natu	re	on	File	
14. DATE OF CURRENT ILLNESS	S, INJURY, or PF		(LMP) 15. (	OTHER DATE		DD	YY	16. DATES PAT						CUPATION YY
17. NAME OF REFERRING PROV	300.00	ER SOURCE	17a.					18. HOSPITALIZ	ATION	DATES	RELAT	ED TO	CURRENT SE	RVICES
			17b.	. NPI				FROM	00			то	IVIIVI DE	,
19. ADDITIONAL CLAIM INFORM	ATION (Designa	ated by NUC	C)					20. OUTSIDE LA	_			\$ CI	HARGES	
DIAGNICOIO OD NATUDE OF	NEOC OD	LILIDY D-I-I		P b-1	(0.45)			YES	X	NO				
21. DIAGNOSIS OR NATURE OF	ILLINESS OH IN	JUHY Helat			, 10	D Ind. 0		22. RESUBMISS CODE	SION	1	ORIG	SINAL RI	EF. NO.	
A. [W230XXD]	В		1700 000			D		23. PRIOR AUT	HORIZ	ATION NU	JMBEF	3		
E	F		G. ∟ K. ∟		_	H. L.								
24. A. DATE(S) OF SERVICE		B. C.	D. PROCEI	DURES, SER		SUPPLIES	E.	F.		G. DAYS	H. EPSDT	l.	DE	J.
From T MM DD YY MM D		CEOF RVICE EMG	CPT/HCP0	in Unusual Ci	MODIFI		DIAGNOSIS POINTER	\$ CHARGES	s	OR UNITS	Family Plan	ID. QUAL.		NDERING VIDER ID. #
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25. FEDERAL TAX I.D. NUMBER	SSN EI	N 26	 PATIENT'S A	CCOUNT NO	), 27.	ACCEPT AS	SIGNMENT?	28. TOTAL CHA	RGE	29.	AMO	NPI UNT PA	ID 30. F	Rsvd for NUC
822699429		-	523Z92		x	YES	s, see back) NO		50				00	
31. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR C (I certify that the statements or apply to this bill and are made Signature on Fil	OR SUPPLIER REDENTIALS I the reverse a part thereof.)	32. S AI 82.	SERVICE FAI C BREN' 25 CLA	CILITY LOCA	TION INFOR	MATION		33. BILLING PR ADVANCEI 8225 CL SAINT LO	OVIDE D II AYT(	RINFO & NJURY	PH# CA	(31 RE	14) 330	-4776
STEVEN STAHLE		a.	NE		D			a.	ΡI	b.				
SIGNED 03/31/23	DATE		1.41,					1.0						



SANSONE & LAUBER 7777 BONHOMME AVE, #2100 SAINT LOUIS, MO 63105

CARRIER HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA 1. MEDICARE MEDICAID TRICARE CHAMPVA 1a. INSURED'S I.D. NUMBER OTHER FECA BLK LUNG (ID#) (For Program in Item 1) (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) X (ID#) n 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX COX SMITH, CARLA COX SMITH, CARLA F |X 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) 1018 TRIFECTA DR Self X Spouse Child Othe 1018 TRIFECTA DR STATE 8. RESERVED FOR NUCC USE STATE PATIENT AND INSURED INFORMATION FLORISSANT MO FLORISSANT MO ZIP CODE TELEPHONE (Include Area Code) TELEPHONE (Include Area Code) ZIP CODE 63034 63034 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX YES X NO FX b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC) YES X NO c. INSURANCE PLAN NAME OR PROGRAM NAME c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? YES X NO SANSONE & LAUBER d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X NO YES If ves. complete items 9. 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature on File DATE 03/31/23 SIGNED Signature on File 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD ΥY MM QUAL. FROM TO QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17a. FROM TO 17b. NPI \$ CHARGES 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? X NO YES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22. RESUBMISSION ICD Ind. 0 ORIGINAL REF. NO A. LW230XXD C. I B. | D. 23. PRIOR AUTHORIZATION NUMBER E. F. L G. K. I DATE(S) OF SERVICE D. PROCEDURES, SERVICES, OR SUPPLIES H. PSD Family Plan 24. A. B. C. E. F. SUPPLIER INFORMATION PLACE OF (Explain Unusual Circumstances)
T/HCPCS | MODIFIER DIAGNOSIS RENDERING ММ CPT/HCPCS MM DD YY **EMG** \$ CHARGES SERVICE POINTER QUAL PROVIDER ID. # 07 06 22 07 06 22 11 62321 2815 24 1 NPI 1376981571 06 22 07 06 22 11 A4550 500 00 1 NPI 1376981571 07 06 22 07 06 22 11 09966 500 00 1 1376981571 8 07 06 22 07 06 22 11 J1100 350 00 1 NPI 1376981571 PHYSICIAN 100 00 1 07 06 22 07 06 22 80176 NPI 1376981571 6 NPI 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use 25. FEDERAL TAX I.D. NUMBER SSN EIN  $|\mathbf{x}|$ X YES \$ 0 00 822699429 17442Z92068 4265 24 ADVANCED INJURY CARE 31, SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION INCLUDING DEGREES OR CREDENTIALS AIC BRENTWOOD (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 8225 CLAYTON ROAD 8225 CLAYTON ROAD Signature on File SAINT LOUIS, MO 63117-1107 SAINT LOUIS, MO 63117-1107 SAMUEL N BARTMESS, M.D. a. SIGNED 03/31/23

DATE



SANSONE & LAUBER 7777 BONHOMME AVE, #2100 SAINT LOUIS, MO 63105

CARRIER APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA 1. MEDICARE MEDICAID TRICARE CHAMPVA 1a. INSURED'S I.D. NUMBER OTHER FECA BLK LUNG (ID#) (For Program in Item 1) (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) X (ID#) n 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX COX SMITH, CARLA COX SMITH, CARLA |X 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 1018 TRIFECTA DR Self X Spouse Child Othe 1018 TRIFECTA DR STATE 8. RESERVED FOR NUCC USE STATE PATIENT AND INSURED INFORMATION FLORISSANT MO FLORISSANT MO ZIP CODE TELEPHONE (Include Area Code) TELEPHONE (Include Area Code) ZIP CODE 63034 63034 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX YES X NO FX b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC) YES X NO c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME YES X NO SANSONE & LAUBER d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X NO YES If ves. complete items 9. 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. DATE 03/31/23 SIGNED Signature on File SIGNED Signature on File 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION ΥY MM DD QUAL. FROM TO QUAL 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. FROM TO 17b. NPI \$ CHARGES 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES X NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22. RESUBMISSION CODE ICD Ind. 0 ORIGINAL REF. NO A. LW230XXD C. I B. | D. 23. PRIOR AUTHORIZATION NUMBER E. F. L G. K. I DATE(S) OF SERVICE D. PROCEDURES, SERVICES, OR SUPPLIES H. PSD Family Plan 24. A. B. C. E F. PHYSICIAN OR SUPPLIER INFORMATION PLACE OF (Explain Unusual Circumstances)
T/HCPCS | MODIFIER DIAGNOSIS RENDERING CPT/HCPCS MM MM **EMG** \$ CHARGES DD DD YY SERVICE POINTER QUAL PROVIDER ID. # 07 20 22 07 20 22 11 99213 550 00 1 NPI 1710553540 2 NPI 3 NPI 4 NPI 5 NPI 6 NPI 27. ACCEPT ASSIGNMENT? 29. AMOUNT PAID 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 28. TOTAL CHARGE 30. Rsvd for NUCC Use  $||\mathbf{x}||$ X YES 550 00 \$ 0 00 822699429 18058Z92068 ADVANCED INJURY CARE 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION INCLUDING DEGREES OR CREDENTIALS AIC BRENTWOOD (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 8225 CLAYTON ROAD 8225 CLAYTON ROAD Signature on File SAINT LOUIS, MO 63117-1107 SAINT LOUIS, MO 63117-1107 KORRIN N TILLEY, PA a. SIGNED 03/31/23 DATE



APPROVED BY NATIONAL UNIFO	ORM CLAIM COMMITTE	EE (NUCC) 02/12											PICA 🗔
1. MEDICARE MEDICAID	TAXABLE TO CONTRACT OF	CHAMPVA	- HEALT	P TH PLAN ——	FECA BLK LUNG		1a. INSURED'S	I.D. NU	JMBER			(For Program	
(Medicare#) (Medicaid#, 2. PATIENT'S NAME (Last Name,		(Member ID			(ID#)	X (ID#)	0 4. INSURED'S N	IANAT /	Loot Nom	- Fire	Nama	Middle Islani	
COX SMITH, CAR		aı)	3. PATIENT'S	D YY	м□	FX	COX SM			2000		Middle Initial)	
5. PATIENT'S ADDRESS (No., St			6. PATIENT R	ELATIONSHIP			7. INSURED'S A		<u> </u>				
1018 TRIFECTA	DR		Self X S	Spouse Ch	nild	Other	1018 TF	RIF	ECTA	DR			
CITY		STATE	8. RESERVED	FOR NUCC I	USE		CITY						STATE
FLORISSANT		MO					FLORISS	SAN'	T				MO
ZIP CODE	TELEPHONE (Include	Area Code)					ZIP CODE			TEL	EPHONE /	E (Include Area	Code)
63034 9. OTHER INSURED'S NAME (La	( ) -		40 IO DATIEN	ITIO CONDITIO	ON DELAT	ED TO:	63034	DOL 10	V ODOLIE	) OD F	(	) -	
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a. OTHER INSURED'S POLICY C	R GROUP NUMBER		a. EMPLOYME	ENT? (Current	or Previou	ıs)	a. INSURED'S D	ATE C	F BIRTH			SEX	
			Г	YES	X NO		MM	DD	YY		М		FX
b. RESERVED FOR NUCC USE			b. AUTO ACC	IDENT?		ACE (State)	b. OTHER CLAI	M ID (	Designated	by N	UCC)		
				YES	X NO								
c. RESERVED FOR NUCC USE			c. OTHER AC	establishes various.			c. INSURANCE					AME	
			L	YES	Х ио		SANSONE						
d. INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM Co	ODES (Design	ated by N	JCC)	d. IS THERE AN						-101
READ	BACK OF FORM BEFO	RE COMPLETING	& SIGNING TH	HIS FORM			13. INSURED'S	OR AU			•	e items 9, 9a, a	2000/08/200
<ol> <li>PATIENT'S OR AUTHORIZED to process this claim. I also required below.</li> </ol>	PERSON'S SIGNATUR	RE I authorize the r	elease of any m	edical or other				nedical	benefits to			ned physician or	
SIGNED Signature	e on File		DAT	<sub>E</sub> 03/31	./23		SIGNED	Sig	natu	re	on	File	
14. DATE OF CURRENT ILLNES	S, INJURY, or PREGNAI	NCY (LMP) 15. QUA	OTHER DATE	ММ	DD	YY	16. DATES PATI MM FROM	IENT U	INABLE T	o wo	RK IN C	URRENT OCCU	IPATION YY
17. NAME OF REFERRING PRO	VIDER OR OTHER SOU	JRCE 17a.					18. HOSPITALIZ	ATION	DATES	RELAT	ED TO	CURRENT SER	VICES
		17b.	. NPI				FROM				то		
19. ADDITIONAL CLAIM INFORM	ATION (Designated by N	NUCC)					20. OUTSIDE LA	_	1		\$ CI	HARGES	
21. DIAGNOSIS OR NATURE OF	II I NESS OD IN II IDV	Dalata A I to assai	as line below (2	ME)			YES	X	NO				
				, ICD II	nd.   0		22. RESUBMISS CODE	SION	1	ORIG	SINAL RI	EF. NO.	
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E	F	_ G. ∟ K. ∟			H. L L.								
24. A. DATE(S) OF SERVICE	В.	C. D. PROCEI	DURES, SERVI	CES, OR SUP		E.	F.		G. DAYS	H. EPSDT	I.		J.
From T MM DD YY MM D	O PLACE OF SERVICE E		in Unusual Circi CS	MODIFIER		DIAGNOSIS POINTER	\$ CHARGES	5	OR UNITS	Family Plan	ID. QUAL.		DERING DER ID. #
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25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S A	CCOLINT NO	27 400	PEDT ACC	IGNMENTS	28. TOTAL CHA	BGE	20	AMO	NPI UNT PA	D 30 B	d for NUCC U
322699429		19022Z92			govt. claims,	IGNMENT? see back)	SCHOOL MICHIGANICAL STREETS	50 (	1			00 30. HSV	d for NOCC U
31. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR C (I certify that the statements or apply to this bill and are made Signature on Fil	OR SUPPLIER REDENTIALS In the reverse a part thereof.)	32. SERVICE FAI AIC BREN' 8225 CLA SAINT LO	CILITY LOCATI TWOOD YTON RO	ON INFORMA	TION	INO	33. BILLING PRO ADVANCEI 8225 CLA SAINT LO	OVIDE II C	RINFO & NJURY	PH# CA	(31 RE	4) 330-	4776
LINDSEY S PATE	RSON, PA-		31 6					DI	L				
SIGNED 03/31/23	DATE	a. NF	b.				a.	M	b.				



SANSONE & LAUBER 7777 BONHOMME AVE, #2100 SAINT LOUIS, MO 63105

CARRIER APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA 1. MEDICARE MEDICAID TRICARE CHAMPVA 1a. INSURED'S I.D. NUMBER OTHER FECA BLK LUNG (ID#) (For Program in Item 1) (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) X (ID#) n 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX COX SMITH, CARLA COX SMITH, CARLA F |X 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self X Spouse 1018 TRIFECTA DR Child Othe 1018 TRIFECTA DR STATE 8. RESERVED FOR NUCC USE STATE PATIENT AND INSURED INFORMATION FLORISSANT MO FLORISSANT MO TELEPHONE (Include Area Code) TELEPHONE (Include Area Code) ZIP CODE ZIP CODE 63034 63034 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX YES X NO FX b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC) X NO YES c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME YES X NO SANSONE & LAUBER d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X NO YES If ves. complete items 9. 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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T/HCPCS | MODIFIER DIAGNOSIS RENDERING ММ CPT/HCPCS MM DD YY **EMG** \$ CHARGES SERVICE POINTER QUAL PROVIDER ID. # 08 09 22 80 09 22 11 A4550 500 00 1 NPI 1376981571 09 22 80 09 22 11 09966 500 00 1 NPI 1376981571 08 09 22 08 09 | 22 | J1100 350 00 1 1376981571 8 100 00 1 08 09 22 08 09 22 11 80176 NPI 1376981571 PHYSICIAN 08 09 22 08 09 22 11 64483 2658 37 1 NPI 1376981571 6 NPI 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO.  $|\mathbf{x}|$ X YES \$ 0 00 822699429 19294Z92068 4108 37 ADVANCED INJURY CARE 31, SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION INCLUDING DEGREES OR CREDENTIALS AIC BRENTWOOD (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 8225 CLAYTON ROAD 8225 CLAYTON ROAD Signature on File SAINT LOUIS, MO 63117-1107 SAINT LOUIS, MO 63117-1107 SAMUEL N BARTMESS, M.D. a. SIGNED 03/31/23 DATE



APPROVED BY NATIONAL UNIFO	ORM CLAIM COMMITTEE	(NUCC) 02/12							PICA
1. MEDICARE MEDICAID	TRICARE	CHAMPV	A GROUP HEALTH F	PLAN FECA	OTHER	1a. INSURED'S I.D. NU	JMBER		(For Program in Item 1)
(Medicare#) (Medicaid#,	(ID#/DoD#)	(Member II	D#) HEALTH F	PLAN BLK LUNG	(ID#)	0			
2. PATIENT'S NAME (Last Name,	First Name, Middle Initial)		3. PATIENT'S BIR	RTH DATE	SEX	4. INSURED'S NAME (	Last Name, F	First Name,	Middle Initial)
COX SMITH, CAR	LA		IVIIVI DB	М	F X	COX SMITH	, CARI	LA	
5. PATIENT'S ADDRESS (No., St	reet)		6. PATIENT RELA	ATIONSHIP TO INSU	JRED	7. INSURED'S ADDRE	SS (No., Stre	eet)	
1018 TRIFECTA	DR		Self X Spou	use Child	Other	1018 TRIF	ECTA I	OR	
CITY		STATE	8. RESERVED FO	OR NUCC USE		CITY			STATE
FLORISSANT		MO				FLORISSAN'	r		MO
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). OTHER INSURED'S NAME (La	st Name, First Name, Mide	dle Initial)	10. IS PATIENT'S	CONDITION RELA	TED TO:	11. INSURED'S POLIC	Y GROUP O	R FECA NU	JMBER
. OTHER INSURED'S POLICY C	R GROUP NUMBER		a. EMPLOYMENT	? (Current or Previo	us)	a. INSURED'S DATE C	F BIRTH		SEX
				YES X NO		MM   DD	YY	М	F X
. RESERVED FOR NUCC USE			b. AUTO ACCIDE	NT? F	LACE (State)	b. OTHER CLAIM ID (	Designated b	y NUCC)	
				YES X NO					
. RESERVED FOR NUCC USE			c. OTHER ACCID	ENT?	(4	c. INSURANCE PLAN	NAME OR PI	ROGRAM N	AME
				YES X NO		SANSONE &	LAUBI	ER	
. INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM CODE	ES (Designated by N	UCC)	d. IS THERE ANOTHE	R HEALTH B	BENEFIT PL	AN?
						YES X	NO If y	ves, complet	te items 9, 9a, and 9d.
READ 2. PATIENT'S OR AUTHORIZED to process this claim. I also required below.	BACK OF FORM BEFORI PERSON'S SIGNATURE uest payment of governmen	I authorize the	release of any medic	cal or other information	n necessary gnment		benefits to the		SIGNATURE I authorize ned physician or supplier for
SIGNED Signature	e on File		DATE_(	03/31/23		SIGNED Sig	natur	e on	File
4. DATE OF CURRENT ILLNES	S, INJURY, or PREGNANO	CY (LMP) 15.	OTHER DATE	MM   DD	YY	16. DATES PATIENT U	NABLE TO	WORK IN C	URRENT OCCUPATION MM   DD   YY
	JAL.	QUA	AL.	WIWI DD	11	FROM	11	то	WIWI DD   TT
7. NAME OF REFERRING PRO	IDER OR OTHER SOUR	CE 17a				18. HOSPITALIZATION	DATES REI	LATED TO	CURRENT SERVICES MM DD YY
		17b	. NPI			FROM		то	
9. ADDITIONAL CLAIM INFORM	ATION (Designated by NU	JCC)				20. OUTSIDE LAB?	0 1085	\$ CI	HARGES
						YES X	NO		
1. DIAGNOSIS OR NATURE OF	ILLNESS OR INJURY Re	elate A-L to servi	ice line below (24E)	ICD Ind. 0		22. RESUBMISSION CODE	. 0	RIGINAL RI	EF. NO.
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E. L	F. L	G. L		н. 📖		23. PRIOR AUTHORIZ	ATION NUM	BER	
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5. FEDERAL TAX I.D. NUMBER	SSN EIN 2	6. PATIENT'S A	ACCOUNT NO	27. ACCEPT ASS	SIGNMENT?	28. TOTAL CHARGE	29. AI	NPI MOUNT PA	ID 30. Rsvd for NUCC
322699429		991929		27. ACCEPT ASS (For govt. claims	see back)	\$ 550	200,000		00
SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR C (I certify that the statements or apply to this bill and are made ignature on Fill	OR SUPPLIER REDENTIALS In the reverse a part thereof.)  8	2. SERVICE FA IC BREN 225 CLA	CILITY LOCATION TWOOD YTON ROAD	INFORMATION		33. BILLING PROVIDE ADVANCED IN 8225 CLAYTO SAINT LOUIS	RINFO & PH	H# (31 CARE D	14) 330-4776
NICOLE HELLWE	a	. KII	<b>b</b> .			a. NDI	b.		
SIGNED 03/31/23	DATE	. 1/11	U.			- MPI	5.		



APPROVED BY NATIONAL UNIFO	ORM CLAIM COMMITTEE (NUCC) (	/12			PICA 🗔
MEDICARE MEDICAID	TRICARE CHA	MPVA GROUP	FECA OTHER	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
(Medicare#) (Medicaid#,	(Mer	ber ID#) HEALTH PLAN	(ID#) X (ID#)	0	
2. PATIENT'S NAME (Last Name,	1000 100 100 100 100 100 100 100 100 10	3. PATIENT'S BIRTH I	DATE SEX	4. INSURED'S NAME (Last Nam	
COX SMITH, CAR 5. PATIENT'S ADDRESS (No., St		6. PATIENT RELATIO	M F X	COX SMITH, CA	
1018 TRIFECTA	380.530 <b>4</b>	Self X Spouse	Child Other	1018 TRIFECTA	SCHOOL SCHOOL
CITY		TE 8. RESERVED FOR N		CITY	STATE
FLORISSANT	м			FLORISSANT	MO
ZIP CODE	TELEPHONE (Include Area Code)			ZIP CODE	TELEPHONE (Include Area Code)
63034	( )-			63034	( )-
9. OTHER INSURED'S NAME (La	ast Name, First Name, Middle Initial)	10. IS PATIENT'S COI	NDITION RELATED TO:	11. INSURED'S POLICY GROUP	P OR FECA NUMBER
a. OTHER INSURED'S POLICY C	OR GROUP NUMBER	a. EMPLOYMENT? (C		a. INSURED'S DATE OF BIRTH	SEX
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?		L OTHER OLAMAIR (Basinests	M F X
D. FILOLITY ED FORTING GOL		YES	PLACE (State)	b. OTHER CLAIM ID (Designate	a by NOCC)
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT		c. INSURANCE PLAN NAME OF	R PROGRAM NAME
		YES	The same of the sa	SANSONE & LAU	
d. INSURANCE PLAN NAME OR	PROGRAM NAME	10d. CLAIM CODES (I		d. IS THERE ANOTHER HEALT	
				YES X NO	If yes, complete items 9, 9a, and 9d.
12. PATIENT'S OR AUTHORIZED	BACK OF FORM BEFORE COMPLIDERSON'S SIGNATURE I authorize uest payment of government benefits	the release of any medical or	other information necessary		ED PERSON'S SIGNATURE I authorize to the undersigned physician or supplier for
SIGNED Signature	e on File	DATE 03	/31/23	SIGNED Signatu	re on File
14. DATE OF CURRENT ILLNES	S, INJURY, or PREGNANCY (LMP)	15. OTHER DATE QUAL. MI			O WORK IN CURRENT OCCUPATION MM DD YY
17. NAME OF REFERRING PROV	(300.00)	17a.		1 1	RELATED TO CURRENT SERVICES
		17b. NPI		FROM DD Y	TO DD YY
19. ADDITIONAL CLAIM INFORM	IATION (Designated by NUCC)	processors and proces		20. OUTSIDE LAB?	\$ CHARGES
				YES X NO	
21. DIAGNOSIS OR NATURE OF	ILLNESS OR INJURY Relate A-L to	service line below (24E)	ICD Ind. 0	22. RESUBMISSION CODE	ORIGINAL REF. NO.
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E	F. L	a. L	н. 🖳	23. PRIOR AUTHORIZATION N	OMBER
I. L. DATE(S) OF SERVICE		K. L OCEDURES, SERVICES, O	L. L. E.	F. G.	H. I. J.
	o PLACE OF	xplain Unusual Circumstanc			H. I. J. EPSDT ID. RENDERING PROVIDER ID. #
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					NPI NPI
25. FEDERAL TAX I.D. NUMBER	SSN EIN 26. PATIEN	'S ACCOUNT NO. 2	7. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29	. AMOUNT PAID 30. Rsvd for NUCC Us
822699429	<b>X</b> 20028	292068 [	X YES NO	\$ 5428 98 \$	0 00
31. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR C (I certify that the statements or apply to this bill and are made Signature on Fil	OR SUPPLIER REDENTIALS n the reverse a part thereof.)  Le 32. SERVIC AIC BI 8225 ( SAINT	EFACILITY LOCATION INFO ENTWOOD LAYTON ROAD LOUIS, MO 631		33. BILLING PROVIDER INFO & ADVANCED INJURY 8225 CLAYTON RC SAINT LOUIS, MC	CARE
SAMUEL N BARTM	ESS, M.D.	VIDI b.		a. NDI b.	
SIGNED 03/31/23	DATE a.	NPI b.		a. NPI b.	



SANSONE & LAUBER 7777 BONHOMME AVE, #2100 SAINT LOUIS, MO 63105

CARRIER APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA 1. MEDICARE MEDICAID TRICARE CHAMPVA 1a. INSURED'S I.D. NUMBER OTHER FECA BLK LUNG (ID#) (For Program in Item 1) (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) X (ID#) n 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX COX SMITH, CARLA COX SMITH, CARLA |X 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self X Spouse 1018 TRIFECTA DR Child Othe 1018 TRIFECTA DR STATE 8. RESERVED FOR NUCC USE STATE PATIENT AND INSURED INFORMATION FLORISSANT MO FLORISSANT MO TELEPHONE (Include Area Code) TELEPHONE (Include Area Code) ZIP CODE ZIP CODE 63034 63034 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX YES X NO FX b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? b. OTHER CLAIM ID (Designated by NUCC) PLACE (State) X NO YES c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME YES X NO SANSONE & LAUBER d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X NO YES If ves. complete items 9. 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature on File DATE 03/31/23 SIGNED Signature on File 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD ΥY MM QUAL. FROM TO QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17a. FROM TO 17b. NPI \$ CHARGES 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES X NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22. RESUBMISSION ICD Ind. 0 ORIGINAL REF. NO A. LW230XXD C. I B. | D. 23. PRIOR AUTHORIZATION NUMBER E. F. L G. K. I DATE(S) OF SERVICE D. PROCEDURES, SERVICES, OR SUPPLIES H. PSD Family Plan 24. A. B. C. E. F. SUPPLIER INFORMATION PLACE OF (Explain Unusual Circumstances)
T/HCPCS | MODIFIER DIAGNOSIS RENDERING ММ CPT/HCPCS MM DD YY **EMG** \$ CHARGES SERVICE POINTER QUAL PROVIDER ID. # 08 30 22 80 30 22 11 A4550 500 00 1 NPI 1376981571 30 22 80 30 22 11 80176 100 00 1 NPI 1376981571 08 30 22 08 30 | 22 | 64490 50 3274 98 2 1376981571 8 08 30 22 08 30 22 11 64491 50 1554 00 2 NPI 1376981571 PHYSICIAN 550 00 1 08 30 22 08 30 22 11 99213 NPI 1376981571 6 NPI 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use 25. FEDERAL TAX I.D. NUMBER SSN EIN  $|\mathbf{x}|$ X YES 5978 98 \$ 0 00 822699429 20140Z92068 ADVANCED INJURY CARE 31, SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION INCLUDING DEGREES OR CREDENTIALS AIC BRENTWOOD (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 8225 CLAYTON ROAD 8225 CLAYTON ROAD Signature on File SAINT LOUIS, MO 63117-1107 SAINT LOUIS, MO 63117-1107 SAMUEL N BARTMESS, M.D. a. SIGNED 03/31/23 DATE



SANSONE & LAUBER 7777 BONHOMME AVE, #2100 SAINT LOUIS, MO 63105

CARRIER APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA 1. MEDICARE MEDICAID TRICARE CHAMPVA 1a. INSURED'S I.D. NUMBER OTHER FECA BLK LUNG (ID#) (For Program in Item 1) (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) X (ID#) n 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX COX SMITH, CARLA COX SMITH, CARLA F |X 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self X Spouse 1018 TRIFECTA DR Child Othe 1018 TRIFECTA DR STATE 8. RESERVED FOR NUCC USE STATE PATIENT AND INSURED INFORMATION FLORISSANT MO FLORISSANT MO ZIP CODE TELEPHONE (Include Area Code) TELEPHONE (Include Area Code) ZIP CODE 63034 63034 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX YES X NO FX b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC) X NO YES c. INSURANCE PLAN NAME OR PROGRAM NAME c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? YES X NO SANSONE & LAUBER d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X NO YES If ves. complete items 9. 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature on File DATE 03/31/23 SIGNED Signature on File 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD ΥY MM QUAL. FROM TO QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17a. FROM TO 17b. NPI \$ CHARGES 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES X NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22. RESUBMISSION ICD Ind. 0 ORIGINAL REF. NO A. LW230XXD C. I B. | D. 23. PRIOR AUTHORIZATION NUMBER E. F. L G. K. I DATE(S) OF SERVICE D. PROCEDURES, SERVICES, OR SUPPLIES H. PSD Family Plan 24. A. B. C. E. F. SUPPLIER INFORMATION PLACE OF (Explain Unusual Circumstances)
T/HCPCS | MODIFIER DIAGNOSIS RENDERING ММ CPT/HCPCS MM DD YY **EMG** \$ CHARGES SERVICE POINTER QUAL PROVIDER ID. # 09 08 22 09 08 22 11 A4550 500 00 1 NPI 1376981571 08 22 09 80 22 11 80176 100 00 1 NPI 1376981571 09 08 22 09 08 | 22 | 99213 550 00 1 1376981571 8 09 08 22 09 08 22 11 64633 50 17000 00 2 NPI 1376981571 PHYSICIAN 8000 00 2 09 08 22 09 08 22 11 64634 50 NPI 1376981571 6 NPI 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use 25. FEDERAL TAX I.D. NUMBER SSN EIN  $|\mathbf{x}|$ X YES \$ 0 00 822699429 20418Z92068 26150 00 ADVANCED INJURY CARE 31, SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION INCLUDING DEGREES OR CREDENTIALS AIC BRENTWOOD (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 8225 CLAYTON ROAD 8225 CLAYTON ROAD Signature on File SAINT LOUIS, MO 63117-1107 SAINT LOUIS, MO 63117-1107 SAMUEL N BARTMESS, M.D. a. SIGNED 03/31/23 DATE



		PICA
. MEDICARE MEDICAID TRICARE	DEALTH DLAN DIVING	R 1a. INSURED'S I.D. NUMBER (For Program in Item 1
(Medicare#) (Medicaid#) (ID#/DoD#)	Member ID#) (ID#) (ID#) (ID#) (ID#) (ID#)	0
. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
OX SMITH, CARLA	MIM F X	COX SMITH, CARLA
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
.018 TRIFECTA DR	Self X Spouse Child Other	1018 TRIFECTA DR
CITY	STATE 8. RESERVED FOR NUCC USE	CITY STATE
CLORISSANT	MO	FLORISSANT MO
-1		
TELEPHONE (Include Area Co	de)	ZIP CODE TELEPHONE (Include Area Code)
3034 ( ) –		63034   ( ) -
OTHER INSURED'S NAME (Last Name, First Name, Middle Init	ial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
	YES X NO	MM   DD   YY M F X
RESERVED FOR NUCC USE	h AUTO ACCIDENT?	L OTHER OLD MINUS (D. ). I I I MINOS
	YES X NO	)
DECEDIED FOR MILES LICE		- INCUDANCE DI ANI MAME OD COCCO
RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	SANSONE & LAUBER
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES X NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COM	PLETING & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I auth to process this claim. I also request payment of government bene		payment of medical benefits to the undersigned physician or supplier services described below.
below.	, ,	
SIGNED Signature on File	DATE 03/31/23	SIGNED Signature on File
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LM MM $\mid$ DD $\mid$ YY	IP) 15. OTHER DATE MM   DD   YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM   DD   YY MM   DD   YY
QUAL.	QUAL.	FROM TO
NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
	17b. NPI	FROM TO
. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
		YES X NO
. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A	-L to service line below (24E)	22. RESUBMISSION
	icD ina.   0	CODE ORIGINAL REF. NO.
A. [W230XXA] B. [M542]	c. <u>M545</u> D	23. PRIOR AUTHORIZATION NUMBER
E. L	G н	25. PRIOR AUTHORIZATION NOMBER
J	K L	-
I. A. DATE(S) OF SERVICE   B.   C.   D.   From   To   PLACE OF	PROCEDURES, SERVICES, OR SUPPLIES E. (Explain Unusual Circumstances)	F. G. H. I. J. DAYS EPSOT ID. RENDERING
	CPT/HCPCS   MODIFIER POINTER	
9 22 22 09 22 22 11 9	9213 ABC	550 00 1 NPI 1912584509
		NPI
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		NPI
FEDERAL TAX I.D. NUMBER SSN EIN 26, PAT	TIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	
AN ADDRESS AND AN ADDRESS OF THE PARTY OF TH	(For govt. claims, see back)	
22699429     X   214	57Z92068 X YES NO	\$ 550 00 \$ 0 00
	RVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (314) 330-4776
SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SEF		
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	BRENTWOOD	ADVANCED INJURY CARE
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereot.)  32. SEF AIC 8225	CLAYTON ROAD	ADVANCED INJURY CARE 8225 CLAYTON ROAD
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  32. SEF AIC 8225		ADVANCED INJURY CARE



PICA		PICA
I. MEDICARE MEDICAID TRICARE CHA	LEALTH DLAN DIVILING	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
	er ID#) (ID#) (ID#) (ID#)	0
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
COX SMITH, CARLA	M F X	COX SMITH, CARLA
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
L018 TRIFECTA DR	Self X Spouse Child Other	1018 TRIFECTA DR
CITY ST.	E 8. RESERVED FOR NUCC USE	CITY STATE
FLORISSANT MO		FLORISSANT MO
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
33034 ( )-		63034 ( ) -
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
OTHER INSURED S POLICY OR GROUP NUMBER		MM   DD   YY
. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	M F X
	PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	A INCUIDANCE DI ANI NAME OD DECORAMINAME
. NESERVED FOR NUCL USE		C. INSURANCE PLAN NAME OR PROGRAM NAME
I INCLIDANCE DI ANNANE CO COCCO	YES X NO	SANSONE & LAUBER
. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BEFORE COMPLE	ING & CICKING THIS FORM	YES X NO If yes, complete items 9, 9a, and 9d.
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this claim. I also request payment of government benefits e below.</li> </ol>	ne release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier is services described below.
SIGNED Signature on File	DATE 03/31/23	SIGNED Signature on File
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	5. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM   DD   YY
MM DD YY QUAL.	QUAL. MM DD YY	FROM DD YY MM DD YY
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE	7a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
	7b. NPI	FROM TO YY
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	- 1	20. OUTSIDE LAB? \$ CHARGES
		YES X NO
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to	ervice line below (24E) ICD Ind. 0	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. LM542 B. LM545	W230XXD D M25512	Original her. No.
		23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE B. C. D. PF	CEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.  DAYS EPSÖT ID. RENDERING OR Family
	plain Unusual Circumstances) DIAGNOSIS CPCS   MODIFIER POINTER	DAYS HESDI ID. RENDERING Family UNITS Plan QUAL. PROVIDER ID. #
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		NPI
5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIEN	S ACCOUNT NO. 27. ACCEPT, ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUC
Section appropriate programme the section of the se	(For govt. claims, see back)	
322699429 <u> </u>		\$ 550 00 \$ 0 00
INCLUDING DEGREES OR CREDENTIALS	FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (314) 330-4776 ADVANCED INJURY CARE
(I certify that the statements on the reverse	AYTON ROAD	8225 CLAYTON ROAD
apply to the bill and are made a part thereon,	OUIS, MO 63117-1107	SAINT LOUIS, MO 63117-1107
LINDSEY S PATERSON, PA-		
SIGNED 03/31/23 DATE a.	b.	a. b.



PICA		PICA
. MEDICARE MEDICAID TRICARE CHAI	LEALTH DLAN DIVILING	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#)(Medicaid#)(ID#/DoD#)(Mem.  2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		NSURED'S NAME (Last Name, First Name, Middle Initial)
COX SMITH, CARLA	3. PATIENT'S BIRTH DATE SEX	COX SMITH, CARLA
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1018 TRIFECTA DR	Self X Spouse Child Other	1018 TRIFECTA DR
CITY STA		CITY STATE
FLORISSANT		FLORISSANT MO
ZIP CODE TELEPHONE (Include Area Code)	-	ZIP CODE TELEPHONE (Include Area Code)
53034 ( )-		63034 ( ) -
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
,		
I. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH  MM   DD   YY
	YES X NO	MM   DD   YY M F X
. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO	
RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	SANSONE & LAUBER
. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	NAME OF THE PARTY	YES X NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
<ol><li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this claim. I also request payment of government benefits e</li></ol>		payment of medical benefits to the undersigned physician or supplier fo services described below.
below.	= 000 200 1000	
Signature on File	DATE 03/31/23	SIGNED Signature on File
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	OOTHER DATE MM   DD   YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM   DD   YY
QUAL.	UAL.	FROM TO
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE	7a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
	7b. NPI	FROM TO
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
		YES X NO
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to	rvice line below (24E) ICD Ind. 0	22. RESUBMISSION CODE , ORIGINAL REF. NO.
A. [W230XXA] B. [M542]	M25512 D. M545	
E F	L н. L	23. PRIOR AUTHORIZATION NUMBER
I J	L	
	EDURES, SERVICES, OR SUPPLIES E.  DIAGNOSIS  DIAGNOSIS	F. G. H. I. J. DAYS EPSDT ID. RENDERING OR Family
MM DD YY MM DD YY SERVICE EMG CPT/		\$ CHARGES OR UNITS Plan QUAL. PROVIDER ID. #
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25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIEN	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	NPI
Service Control of the Control of th	(For govt. claims, see back)	
322699429 X 24060		\$ 550 00 \$ 0 00
INCLUDING DEGREES OR CREDENTIALS	FACILITY LOCATION INFORMATION  NTWOOD	33. BILLING PROVIDER INFO & PH# (314) 330-4776 ADVANCED INJURY CARE
(I certify that the statements on the reverse	AYTON ROAD	8225 CLAYTON ROAD
Signature on File SAINT	OUIS, MO 63117-1107	SAINT LOUIS, MO 63117-1107
KALEN J VESPOLI, M.D.,	DI .	. NEW
SIGNED 03/31/23 DATE a.	D. b.	a. <b>NP</b> b.



PICA			ITTIMMC	(,											PICA
1. MEDICARE	MEDICAID	TRICA	RE	CH	AMPVA	GRO	UP .TH PLAN	FECA BLK LL	INIC	1a. INSURED'S	I.D. NUMBER			(For Progra	m in Item 1)
(Medicare#)	(Medicaid#)	(ID#/Do	oD#)	(Me	mber ID#)	(ID#)	III FLAN	(ID#)	X (ID#)	0					
. PATIENT'S NAM	IE (Last Name, Fire	st Name, Mi	liddle Initi	ial)	3. F	ATIENT'S	S BIRTH D	DATE	SEX	4. INSURED'S N	NAME (Last Na	me, First	Name,	Middle Initial)	
OX SMIT	H, CARLA	Ą						м	F X	COX SM	ГТН, СА	ARLA			
. PATIENT'S ADD	RESS (No., Street	)			6. 1	PATIENT	RELATIO	NSHIP TO IN	SURED	7. INSURED'S A	ADDRESS (No.	., Street)			
.018 TRI	FECTA DE	ર				Self X	Spouse	Child	Other	1018 TH	RIFECT	A DR			
CITY				S	TATE 8. F	RESERVE	D FOR N	UCC USE		CITY					STATE
FLORISSA	NT			l M	0					FLORISS	SANT				MO
ZIP CODE	TE	LEPHONE	(Include	Area Code						ZIP CODE		TELE	EPHON	E (Include Area	a Code)
53034	(	) -	_							63034			(	) –	
. OTHER INSURE	D'S NAME (Last N	Name, First	Name, M	/liddle Initial)	10.	IS PATIE	NT'S CON	IDITION REL	ATED TO:	11. INSURED'S	POLICY GRO	UP OR F	ECA NU	JMBER	
a. OTHER INSURE	D'S POLICY OR G	ROUP NUI	MBER		a. f	EMPLOYN	MENT? (C	urrent or Pre	vious)	a. INSURED'S I	DATE OF BIRT	Н		SEX	
							YES	X	0	MM I	DD   YY		М		FX
. RESERVED FO	R NUCC USE				b. A	AUTO AC	0.000000	<u> </u>		b. OTHER CLAI	M ID (Designa	ted by NI			
							YES	X	PLACE (State)		io (Designa	Jy 140	200)		
RESERVED FOR	R NUCC USE					THER A	CCIDENT			c. INSURANCE	PLAN NAME (	OR PROC	SRAM N	IAME	
					0.0	- ALIELL PA	YES	, X	0	SANSON				VIL	
INCIDANCED	AN NAME OF PR	OCDANA NIA	NAE.		10-	CLAIRA				d. IS THERE AN				ANIO	
. INSURANCE PL	AN NAME OR PRO	JUNANI NA	NIVIE.		100	. CLAIM	JUDES (L	Designated by	(NOCC)		X NO				
	DEADD	V 05 505	M PEEC	DE COME	ETINO	ICHINO -	TUIC FOR			YES YES		100000000000000000000000000000000000000		te items 9, 9a,	X2270443224344
2. PATIENT'S OR	<b>AUTHORIZED PE</b>	RSON'S SI	IGNATU		ze the relea	se of any i	medical or	other informa			nedical benefit				
to process this of below.	laim. I also request	payment of	f governn	nent benefits	either to my	self or to	the party v	vho accepts a	ssignment		cribed below.		J		
			: 1 ~				0.3	/21 /22	)	l .	a :			m: 1 -	
	gnature						TE_U3,	/31/23			Signat				
14. DATE OF CUR MM   DD	RENT ILLNESS, IN	NJURY, or F	PREGNA	NCY (LMP)	15. OTH	ER DATE	MM	/ DD	YY	16. DATES PAT	IENT UNABLE	TO WO			CUPATION
	QUAL	.			QUAL.	i				FROM			TO		
17. NAME OF REF	ERRING PROVIDE	ER OR OTH	HER SOL	JRCE	17a.					18. HOSPITALIZ MM	ATION DATES	S RELAT YY	ED TO	CURRENT SE MM   DD	RVICES YY
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(I certify that the	e statements on the	e reverse		8225	RENTW CLAYT		מאַכ			ADVANCE 8225 CL			KĽ		
apply to this bill Signature	and are made a page on File	art tnereof.)	)	SAINT	LOUI	S, MC	سمر 631 (	17-110	7	SAINT L			117-	-1107	
_	PALETTA	, <b>м</b> п													
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SANSONE & LAUBER 7777 BONHOMME AVE, #2100 SAINT LOUIS, MO 63105

CARRIER APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA 1. MEDICARE MEDICAID TRICARE CHAMPVA 1a. INSURED'S I.D. NUMBER OTHER FECA BLK LUNG (ID#) (For Program in Item 1) (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) X (ID#) n 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX COX SMITH, CARLA COX SMITH, CARLA F |X 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self X Spouse 1018 TRIFECTA DR Child Othe 1018 TRIFECTA DR STATE 8. RESERVED FOR NUCC USE STATE PATIENT AND INSURED INFORMATION FLORISSANT MO FLORISSANT MO TELEPHONE (Include Area Code) TELEPHONE (Include Area Code) ZIP CODE ZIP CODE 63034 63034 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX YES X NO FX b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC) X NO YES c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME YES X NO SANSONE & LAUBER d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X NO YES If ves. complete items 9. 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature on File DATE 03/31/23 SIGNED Signature on File 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD ΥY MM QUAL. FROM TO QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17a. FROM TO 17b. NPI 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES YES X NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22. RESUBMISSION ICD Ind. 0 ORIGINAL REF. NO A. M25512 C. I B. | D. 23. PRIOR AUTHORIZATION NUMBER E. F. L G. I K. I DATE(S) OF SERVICE D. PROCEDURES, SERVICES, OR SUPPLIES H. PSD Family Plan 24. A. B. C. E. SUPPLIER INFORMATION PLACE OF (Explain Unusual Circumstances)
T/HCPCS | MODIFIER DIAGNOSIS RENDERING ММ CPT/HCPCS MM DD YY **EMG** \$ CHARGES SERVICE POINTER QUAL PROVIDER ID. # 02 13 23 02 13 23 24 29827 LT 80 21138 00 1 NPI 1497720825 13 23 02 13 23 29826 LT 80 15702 80 1 NPI 1497720825 02 13 23 02 13 23 23405 LT 80 12951 85 1 1497720825 8 02 13 23 02 13 23 24 29822 59 LT 80 15425 00 1 NPI 1497720825 SICIAN 02 13 23 02 13 23 23700 59 80 2554 86 1 NPI 1497720825 NPI 1497720825 L3670 02 13 23 02 13 23 24 250 00 1 30. Rsvd for NUCC Use 26. PATIENT'S ACCOUNT NO. 28. TOTAL CHARGE 29. AMOUNT PAID 25. FEDERAL TAX I.D. NUMBER SSN EIN 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)  $||\mathbf{x}||$ X YES \$ 822699429 31972Z92068 68022 51 ST LOUIS SPINE AND ORTHOPEDIC SURADVANCED INJURY CARE 31, SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 1130 TOWN AND COUNTRY COMMONS 8225 CLAYTON ROAD TOWN AND COUNTRY, MO 63017-8200 Signature on File SAINT LOUIS, MO 63117-1107 GEORGE PALETTA, M.D. a. SIGNED 03/31/23 DATE



APPROVED BY NATIONAL UNIFO	TIM CLAIM COMMITT	LL (14000) 02/12								PIC	CA 🔲
1. MEDICARE MEDICAID  (Medicare#) (Medicaid#)	PARTITION OF THE PARTIT	CHAMPV (Member II	- HEALTH	PLAN FECA BLK LUN (ID#)	OTHER G (ID#)	1a. INSURED'S	I.D. NUMBER			(For Program in Itel	m 1)
2. PATIENT'S NAME (Last Name,			3. PATIENT'S BI		SEX	4. INSURED'S N	NAME (Last Nar	ne, First	Name,	Middle Initial)	
COX SMITH, CAR				м	F X	COX SMI	•		•		
. PATIENT'S ADDRESS (No., Str . 018 TRIFECTA	H000000.00E)		Self X Spo	ATIONSHIP TO INS	Other	7. INSURED'S A	Market	COLUMN TESTAN			
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THESE IVED I ON NOOD USE			S. OTHER ACCI	YES X NO		SANSONE				CIVIL	
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				nan Sir S	46	YES	X NO			te items 9, 9a, and 9d	
READ I 2. PATIENT'S OR AUTHORIZED to process this claim. I also required below.		RE I authorize the	release of any med	lical or other information		payment of n				SIGNATURE I author ned physician or supp	
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IT. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR C (I certify that the statements or apply to this bill and are made signature on Fil	OR SUPPLIER REDENTIALS I the reverse a part thereof.)	32. SERVICE FA ST LOUIS 1130 TOW	CILITY LOCATION SPINE AI N AND CO		IONS	33. BILLING PRO	OVIDER INFO D INJUR AYTON R	Y CA OAD	(31 RE	14) 330-477	6
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SIGNED 03/31/23	DATE	a.	D.			a.	P				



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. MEDICARE MEDICAID TRICARE CHAM	DEALTH DLAN DIVILING	1a. INSURED'S I.D. NUMBER (For Program in	Item 1)
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
COX SMITH, CARLA	M F X	COX SMITH, CARLA 7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED		
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. OTHER INSONED 3 NAIME (Last Name, First Name, Middle Illida)	10. 13 FATIENT 3 CONDITION RELATED TO.	11. INSURED 3 FOLIOT GROUP ON FEON NUMBER	
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. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
	YES X NO	SANSONE & LAUBER	
I. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
		YES X NO If yes, complete items 9, 9a, and	9d.
READ BACK OF FORM BEFORE COMPLET		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I aut	thorize
<ol><li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this claim. I also request payment of government benefits eit</li></ol>		payment of medical benefits to the undersigned physician or su services described below.	upplier for
below.	,		
SIGNED Signature on File	DATE_03/31/23	SIGNED Signature on File	
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	5. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUP, MM   DD   MM   DD	ATION
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7. NAME OF REFERRING PROVIDER OR OTHER SOURCE	7a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE MM DD NO.	CES
	7b. NPI	FROM TO	1.1
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	
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A. [ <b>M25512</b> ] В. [	D. I		
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322699429 X 305972 in. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE	92068 X YES NO PACILITY LOCATION INFORMATION	\$ 0 00   \$ 0 00   33. BILLING PROVIDER INFO & PH # (314) 330-47	
INCLUDING DEGREES OR CREDENTIALS		33. BILLING PROVIDER INFO & PH # (314) 330-4" ADVANCED INJURY CARE	776
(I certify that the statements on the reverse	AYTON ROAD	8225 CLAYTON ROAD	
Signature on File SAINT 1	OUIS, MO 63117-1107	SAINT LOUIS, MO 63117-1107	
GEORGE PALETTA, M.D.	DI b.	a. NPI b.	
SIGNED $03/31/23$ DATE $ a $	u.	u.	



APPROVED BY NATIONAL UNIF	ORM CLAIM COMMITTE	EE (NUCC) 02/12											PICA 🗔
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2. PATIENT'S NAME (Last Name	First Name, Middle Initia	al)	3. PATIENT'S	BIRTH DATE		SEX	4. INSURED'S N	IAME (	Last Nam	e, Firs	t Name,	Middle Initial)	
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	/ \	Area Code)								IEL	ephoni (	l (include Area	(Code)
63034  9. OTHER INSURED'S NAME (La	et Nama First Nama M	liddle Initial)	10. IS PATIEN	IT'S CONDITI	ON DELAT	TED TO:	63034	POLIC	V CDOLIE		CA NI	) -	
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c. RESERVED FOR NUCC USE			c. OTHER AC	CIDENT?		(1)	c. INSURANCE	PLAN	NAME OF	PRO	GRAM N	IAME	
			[	YES	X NO		SANSONE	E &	LAU	BER	l .		
d. INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM C	ODES (Desig	nated by N	UCC)	d. IS THERE AN	OTHE	R HEALTH	H BEN	EFIT PL	AN?	
							YES	X	NO	If yes,	complet	te items 9, 9a,	and 9d.
READ  12. PATIENT'S OR AUTHORIZED  to process this claim. I also requely below.	BACK OF FORM BEFO PERSON'S SIGNATUR lest payment of governm	RE I authorize the	release of any m	nedical or other	r informatio	n necessary gnment	13. INSURED'S payment of n services des	nedical	benefits t			SIGNATURE I ned physician	
SIGNED Signature	on File		DAT	E 04/28	3/23		SIGNED	Sig	natu	re	on	File	
14. DATE OF CURRENT ILLNES	, INJURY, or PREGNAI	NCY (LMP) 15.	OTHER DATE	MM	DD ı	YY	16. DATES PAT						UPATION
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19. ADDITIONAL CLAIM INFORM	ATION (Designated by N	NUCC)					20. OUTSIDE LA	_	9 14		\$ CI	HARGES	
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21. DIAGNOSIS OR NATURE OF	ILLNESS OR INJURY	Helate A-L to serv	ice line below (2	<sup>24E)</sup> ICD I	Ind. 0		22. RESUBMISS CODE	SION	1	ORIG	SINAL RI	EF. NO.	
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I	J. L. B.	K C. D. PROCE	DURES, SERV		L. L		F.		G.	Н	I.		J.
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31. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR C (I certify that the statements o apply to this bill and are made	REDENTIALS I the reverse a part thereof.)	32. SERVICE FA AIC BREN 8225 CLA SAINT LO	TWOOD YTON RO	AD			33. BILLING PRO ADVANCEI 8225 CLA SAINT LO	II C	NJURY ON RO	CA AD	ARĖ	14)330- -1107	-4776
Signature on Fil GEORGE PALETI	e A, M.D.	SAINT LO	UIS, MO	0211/	-110/		SAINT L	OOT;	5, MO	0.3	этт/-	-110/	
GEORGE PALETT SIGNED 04/28/23	A, M.D.	a. NI	D.				a.	DΙ	b.				

Case 23-13359-VFP 11:57 AM

Doc 2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Desc

Exhibit E Page 34 of 45 Goldsmith MediCenter Pharmacy 13354 Manchester Rd.

Saint Louis, MO 63131 Phone:(314) 432-5020 Fax:(314) 432-5026 Fed. Id:81-3435121 NABP:2643662

NPI:1730638958

03/13/2023

Phone:(314) 914-5663 Cell:( ) - DOB:

COX SMITH, CARLA

FLORISSANT, MO 63034

1018 TRIFECTA DR

# Profile From:05/12/2022 thru 03/13/2023

Fill Date	Rx Num.	Qty	Drug	NDC	Doctor	Copay	Day Supply
09/01/2022	3025257	1	DIAZEPAM 10MG TABLET	00172-3927-80	BARTMESS, SAMUEL	\$10.00	1
09/01/2022	2063943	1	HYDROCODONE/APAP 10-325MG TABLET	00406-0125-10	BARTMESS, SAMUEL	\$10.00	1
02/08/2023	1184026	10	ONDANSETRON 8MG TABLET	16714-0160-01	PALETTA, GEORGE	\$391.29	4
02/08/2023	1184025	20	KETOROLAC 10MG TABLET	00093-0314-01	PALETTA, GEORGE	\$47.14	5
02/08/2023	2068970	30	HYDROCODONE/APAP 7.5-325MG TABLET	43386-0357-01	PALETTA, GEORGE	\$27.11	5

SAINT LOUIS MO 63105

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/1	2	PICA [	
MEDICARE MEDICAID TRICARE CHAM	PVA GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
(Medicare #) (Medicaid #) (ID#/DoD#) (Memb	er ID#) HEALTH PLAN BLK LUNG (ID#)	358562993	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
COX SMITH , CARLA,  5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	COX-SMITH, CARLA 7. INSURED'S ADDRESS (No., Street)	
1018 TRIFECTA DR	Self XSpouse Child Other	1018 TRIFECTA DR	
CITY STA	TE 8. RESERVED FOR NUCC USE	CITY STATE	
FLORISSANT  ZIP CODE TELEPHONE (Include Area Code)	MO	FLORISSANT M ZIP CODE TELEPHONE (Include Area Code)	.0
63034 (314) 9145663		63034	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
	XYES NO MO		
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
HAZEL WOOD SCHOOL DIST	YES XIO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	O
G. INGONANCE PLAN WAME ON PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	YES XO If yes, complete items 9, 9a and 9d.	
READ BACK OF FORM BEFORE COMPLET		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize	
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the process this claim. I also request payment of government benefits below.</li> </ol>	ne release of any medical or other information necessary either to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below.	
		202	
SIGNED SOF  14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	DATE 03 07 2023	SIGNED SOF  16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
MM , DD , YY	QUAL 439 05 12 2022	FROM DD YY TO MM DD YY	
	17a. 1GG20068	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
	17b. NPI 1497720825	FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  NILATERAL	ERVICAL PLEXUS BLOCK U	DO. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to s	service line below (24E) ICD Ind. 0	22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. G89.18 B.		CODE ORIGINAL REF. NO.	
E F. <u>L</u> G	н. Ц.	23. PRIOR AUTHORIZATION NUMBER	
I. J. K 24. A. DATE(S) OF SERVICE B. C. D. PF	COCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.	_
	Explain Unusual Circumstances)  HCPCS   MODIFIER POINTER	DAYS PERDIT ID. RENDERING OR UNITS Family QUAL. PROVIDER ID. #	
02132023 22 64	415 59 LT A	1200 00 1 NPI 111490186	35
02132023   22   64	999   51   59   LT   A	880 00 1 NP 111490186	55
			65 65
02132023 22 76	942   26   59   A	1050 00 1 NPI 111490186	55
		100	
		l NPI	
		NPI NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT	S ACCOUNT NO.   127, ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC	
	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)  X/ES NO	\$ 3130, 00s 0 000	400
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS  32. SERVICE	FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # ( 866 6060153	3
(I certify that the statements on the reverse STL	SPINE/ORTHO CTR ACUTE	PREMIER ANESTHESIA, LLC	
	TOWN & COUNTRY CMNS TERFIELD MO 63017-8200	PO BOX 5480 CAROL STREAM IL 60197-5480	
SIGNED 03 07 22023 a.	121111111111111111111111111111111111111	a 1225073828b.	
NI ICC Instruction Manual available at www pucc ord	PLEASE PRINT OF TYPE	APPROVED OMB 0039-1107 FORM 1500 /0/	

# \$C256 209133599VFP PDGE 2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Desc

Exhibit E BENGE AND 60NES

7777 BONHOMME AVE SUITE 2100

SAINT LOUIS MO 63105

STL1 329

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/	12		PICA T
1. MEDICARE MEDICAID TRICARE CHAN	HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in It	tem 1)
(Medicare #) (Medicaid #) (ID#/DoD#) (Memb. 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	oer ID#) (ID#) (ID#) XID#)  3. PATIENT'S BIRTH DATE SEX	358562993 4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
COX SMITH , CARLA,	MM DD YY	COX-SMITH, CARLA	
. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
1018 TRIFECTA DR	Self Spouse Child Other  TE 8. RESERVED FOR NUCC USE	1018 TRIFECTA DR	TATE
	MO	FLORISSANT	MO
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Cod	le)
63034 (314 9145663	40 IO DATIFALTIO CONDITION DEL ATED TO	63034 ( )	
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S FOLICT GROUP ON FECA NUMBER	
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX	
DESCRIPTION FOR AUTOO HOS	b. AUTO ACCIDENT?	M F	x
RESERVED FOR NUCC USE	PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
HAZEL WOOD SCHOOL DIST	YES NO	A 10 THERE ANOTHER HEALTH REPORTED AND	7800
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES XO # yes, complete items 9, 9a and 9	ed.
READ BACK OF FORM BEFORE COMPLE 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize i	TING & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I auth payment of medical benefits to the undersigned physician or su	norize
to process this claim. I also request payment of government benefits below.	either to myself or to the party who accepts assignment	services described below.	ipplier for
SIGNED SOF	DATE 03 07 2023	SIGNED SOF	
I. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPA	TION
05 12 2022 QUAL 431	QUAL 439 05 12 2022	FROM MM DD YY TO MM DD TO	* * *
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE  DN GEORGE A PALETTA MD	178. 1GG20068 17b. NPI 1497720825	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE  MM   DD   YY	ES
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	176. NET 2137720020	20. OUTSIDE LAB? \$ CHARGES	
4. DIACHOOLO OR NATURE OF ILL MESO OR IN HIRV Robert All to		YES XIO	
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, Relate A-L to	. 943 432A	22. RESUBMISSION CODE ORIGINAL REF. NO.	
F. L	. Language	23. PRIOR AUTHORIZATION NUMBER	
J. L.	L.L.		
From To PLACE OF	ROCEDURES, SÉRVICES, OR SUPPLIES (Explain Unusual Circumstances)  E. DIAGNOSIS	F. G. H. I. J. DAYS EPSDIT ID. RENDER	
BEG=1445 END=1631 BASEU=	HCPCS   MODIFIER   POINTER   FOINTER   MODIFIER   MODIFIER   MODIFIER   POINTER   MODIFIER   MODIFI	\$ CHARGES OR Family QUAL. PROVIDER 13.0	
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	9.00	NPI	
		NC)	
		NPI	
		l NPI	
		1401	
		NPI	
		MP	
5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIEN	T'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		or NUCC use
	0096901 Xes No	s 1950 00s 0 00	0152
INCLUDING DEGREES OR CREDENTIALS	SPINE/ORTHO CTR OR OP	PREMIER ANESTHESIA, LLC	
apply to this hill and are made a part thorout	TOWN & COUNTRY CMNS	PO BOX 5480	
	STERFIELD MO 63017-820		480
GNED 03 07 DA 2023 a.	b.	а. 1225073828ь.	

# Case 023 13359-VFP ProcE2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Desc

Exhibit E BENG STOPUS
7777 BONHOMME AVE

7777 BONHOMME AVE SUITE 2100 SAINT LOUIS MO 63105 STL1 329

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	PICA TT
MEDICARE MEDICAID TRICARE CHAMP	VA GROUP FECA OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#) (Member	3303023
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)  COX - SMTTH - CARLA
COX-SMITH, CARLA 5 PATIENT'S ADDRESS (No., Street)	F F COX-SMITH, CARLA  6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street)
1018 TRIFECTA DR	Self XSpouse Child Other 1018 TRIFECTA DR
CITY * STATE	E 8. RESERVED FOR NUCC USE CITY STATE
FLORISSANT  ZIP CODE TELEPHONE (Include Area Code)	FLORISSANT  ZIP CODE  63034  10. IS PATIENT'S CONDITION RELATED TO:  11. INSURED'S POLICY GROUP OR FECA NUMBER
63034 (314) 9145663	63034
OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)  a. INSURED'S DATE OF BIRTH  SEX  XYES  NO  F X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?  PLACE (State)  b. OTHER CLAIM ID (Designated by NUCC)
	XVES NO MO
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?
UNKNOWN d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)  d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	YES NO # yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETII  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the	NG & SIGNING THIS FORM. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
to process this claim. I also request payment of government benefits elbelow.	ther to myself or to the party who accepts assignment services described below.
SIGNED SOF	DATE 08 01 2023 SIGNED SOF
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15	5. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
03 12 2022401. 131	UAL. 439 05 12 2022 FROM TO
	78. 1GG20068  18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM   DD   YY  MM   DD   YY
DE: 0201102 11 11122111	7b. NPI 1497720825 FROM TO SCHARGES
NILATERAL	YES XNO
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, Relate A-L to se	ervice line below (24E) ICD Ind. 0 22. RESUBMISSION CODE ORIGINAL REF. NO.
A. G89.18 B. C.	D. L
E. F. G.	H. L.
	DCEDURES, SERVICES, OR SUPPLIES E. F. G. H. I. J. xplain Unusual Circumstances) DIAGNOSIS DAYS EPSOT ID. RENDERING
MM DD YY MM DD YY SERVICE EMG CPT/HC	DIAGNOSIS CON FRANCISCO
07172023 22 644	115   59 LT   A   1160 00 1   NPI 1114901865
22 022	
07172023 22 649	999 51 59 LT A 1080 00 1 NPI 1114901865
07172023   22   769	942 26 59 A 1040 00 1 NPI 1114901865
0/1/2023 24 765	942 26 59 A 1040 00 1 NPI 1114901865
	NPI NPI
	NPI NPI
	NPI NPI
	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use
	099114 Xes NO \$ 3280 00\$ 0 00 FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH. # ( 877) 7467090
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements op the reverse	SPINE/ORTHO CTR ACUTE PREMIER ANESTHESIA, LLC
apply to this bill and are made a part thereof.)	TOWN & COUNTRY CMNS PO BOX 5480
	TERFIELD MO 63017-8200 CAROL STREAM IL 60197-5480
SIGNED 08 01 DAZE023 a.	b. a. 1225073828b.

Desc. Case 23 13359-VFP Dec 2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Desc.

Exhibit E BEAGE 39 SPUS 7777 BONHOMME AVE SUITE 2100 SAINT LOUIS MO 63105

STL1 329

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	2	PICA TTT
1. MEDICARE MEDICAID TRICARE CHAMP	VA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#) (Member	(ID#) (ID#) (ID#)	358562993
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM   DD   YY 11 22 1959 F F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)  COX - SMITH, CARLA
COX - SMITH, CARLA 5. PATIENT'S ADDRESS (No., Street)	11 22 1959 F F 6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1018 TRIFECTA DR	Self Spouse Child Other	1018 TRIFECTA DR
CITY		CITY
FLORISSANT  ZIP CODE   TELEPHONE (Include Area Code)	10	FLORISSANT MO
63034 (314 9145663		63034
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		- INDUDEDID DATE OF DIDTU
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH  MM DD YY  11 22 1959 M F X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	L OTHER CLAIM ID (Designated by AULOC)
	XYES NO MO	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
UNKNOWN d. INSURANCE PLAN NAME OR PROGRAM NAME	YES NO  10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
a. Hoolbarde I Barriagae of Fredrick Walle	(35 day 1000)	YES NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETI 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits e below.	ither to myself or to the party who accepts assignment	services described below.
	00 01 0023	SIGNED SOF
SIGNED SOF  14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 11.	DATE 08 01 2023 5. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
05 12 2022 QUAL 431	WAL 439 05 12 2022	FROM DD , YY TO MM , DD , YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	7a. 1GG20068	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM   DD   YY MM   DD   YY
DN GEORGE A PALETTA MD  19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	7b. NPI 1497720825	FROM TO TO 20. OUTSIDE LAB? \$ CHARGES
To ADDITIONAL OLDINI IN OTHER LONG (Designated by NOCC)		YES XIO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, Relate A-L to se	ervice line below (24E) ICD Ind. 0	22. RESUBMISSION CODE ORIGINAL REF. NO.
A M75.102 B M75.42 C.	D.	
E G.	Н. Ц	23. PRIOR AUTHORIZATION NUMBER
- /-	DCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.
TO TOOL OF	xplain Unusual Circumstances)  CPCS   MODIFIER POINTER	\$ CHARGES   UNITS   Plan   QUAL.   PROVIDER ID. #
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25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT	S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use
	099113 (For govt. claims, see back)	s 1800 00s 0 00
INCLUDING DEGREES OR CREDENTIALS	FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # ( 877 7467090
apply to this bill and are made a part thereof )	SPINE/ORTHO CTR OR OP TOWN & COUNTRY CMNS	PREMIER ANESTHÉSIA, LLC PO BOX 5480
	TERFIELD MO 63017-820	
SIGNED 08 01 DAZ-023 a.	b.	a 1225073828 E1066039
JUCC Instruction Manual available at: www.pucc.org	DI EACE DOWN OD TYPE	APPROVED OMP 0000 1107 FORM 1500 (00 10)

Page: 2 of 7 05/01/2023 11:51 AM Case 23-13359-VFP Doc 2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Desc Exhibit E Page 39 of 45 From: BHS Connect

CERTIFICATION OF MEDICAL RECORDS 239345

Patient Name:	Carla Cox	
I hereby certify that to 8 pages	the documents attached to/accompanying this certificate, consis and/or images, for Total Access Urgent Care, or otherwise	ting of if delivered
in an electronic form records of the patient	at, are accurate and complete duplicates of the original medical	/billing
Exclusions: None / A	As follows:	
······		
revealed no documer produced records are	of No Records (CNR): A thorough search of the files at this locates, medical records or other materials requested. I further certificate a true copy of all records requested and are kept in the course of the cour	y that the of regularly
charged with perfor	cords Custodian, I am an employee of BHS, the Business As rming such searches and certifications.	ssociate
(Signature)	Chustie Bianchi	<del></del>
(Printed Name)	Christie Bianchi	
(Date) 3/9/23	3	

n: BHS connect Fax: 15136530778 To:  Case 23-13359-VFP Doc 2  Total Access Urgent Care  Billing Department  13861 Manchester Road  St. Louis, MO 63011			Fax: (913) : 01/12/24 Page 40 (	Entere	Page ed 01/12/2/24 NG BY CREDIT TERCARD	e: 6 of 7 1 14:53: CARD FIL	05/01/2023 11:5 30 Desc LOUT BELOW VISA	1 AM
·			CAR	D NUMBER	:		EXP. DATE	
			SIGN	IATURE			AMOUNT ENG	CLOSED
CARLA B COX 1018 TRIFECTA DR FLORISSANT, MO 63034				TEMENT DA /22/2023		ССТ# 032699		
Please check box if address is incorrect or insural information has changed, and indicate change(s)		se		Billing 13861	Access Urge p Departmen Manchester uis, MO 630′	t Road		
To pay you	r bill oı	nline go to:	TAUC.con	n and sele	ect Bill Pay			
	AC	COUNT	SUMMAI	₹Y				
The Insurance Companies on file for these visits: CARLA COX Blue Cross/Blue Shield Medicare	You You You	·	50.00 as co 5 currently available a	in your re	are still pend esponsibility. t.	ding.		
isit Date: 05/13/2022 isit ID: 3642608 atient: CARLA ccation: TAUC12 hysician: Morgan Baer, PA-C CF	IARGES	INSURANCE PAYMENT	CONTRACT SAVINGS	PATIENT PAYMENT	ADJUSTMENT	BALANCE	RESPONSIBLE PARTY	DENIAL CODE
72072 X-ray thoracic spine 3 view \$	123.62	\$30.06	\$90.19	\$0.00	\$0.00	\$3.37	Patient	COPAY
72110 X-ray lumbar spine, min 4 views \$	258.74	\$39.31	\$215.03	\$0.00	\$0.00	\$4.40	Patient	COPAY
A INITIAL ASSESSMENT	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
EAVE PATIENT READY TO DISCHARGE	\$0.00	\$0.00	\$0.00	\$0.00	\$0,00	\$0.00		
	318.00	\$97.20	\$209.93	\$0.00	\$0.00	\$10.87	Patient	COPAY
	250.89	\$40.85	\$205.47	\$0.00	\$0.00	\$4.57	Patient	COPAY
isit Date: 05/13/2022 isit ID: 3642879 atient: CARLA ocation: TAUC12 hysician: CF	951.25 IARGES \$15.00	\$207.42  INSURANCE PAYMENT	\$720.62  CONTRACT SAVINGS	-	\$0.00	\$23.21	RESPONSIBLE PARTY	DENIAL CODE
	\$15.00 \$15.00	\$0.00 \$0.00	\$0.00 \$0.00	\$15.00 \$15.00	\$0.00 \$0.00	\$0.00 \$0.00		

\$0,00

\$0.00

\$30,00

\$0.00

\$0.00

Thank you for your timely payment. Please be aware, that in the event of non-payment, you will be responsible for the collection fee and, if necessary, legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance turned over to an outside agency.

\$30.00

From: BHS Connect

From: BHS Connect 05/01/2023 11:51 AM Desc

Case 23-13359-VFP Doc 2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Exhibit E Page 41 of 45

Explanation of outstanding balance(s):

**PATIENT OWES:** \$39,65 **INSURANCE OWES:** 

\$0.00

COPAY: COPAY

Thank you for your timely payment. Please be aware, that in the event of non-payment, you will be responsible for the collection fee and, if necessary, legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance turned over to an outside agency.

# Medical Bills:

Name of the Provider	Billing Amount
Advanced Injury Care	\$ 121,154.08
Goldsmith Pharmacy	485.54
Premier Anesthesia	5,080.00
Total Access Urgent Care	981.25
St. Luke's CDI	4,763.00
St. Louis Spine & Orthopedic Center	87,206.35
Professional Imaging	5,000.00
Athletico	14,480.00
Lehmen	5,250.00
TOTAL	\$ 244,400.22

Case 23-13359-VFP Doc 2791-7 Filed 01/12/24 Entered 01/12/24 14:53:30 Desc Exhibit E Page 43 of 45

# ADVANCED INJURY CARE

8225 Clayton Road, Saint Louis, MO 631171107

**Surgical Consult Note** 

# **CARLA COX SMITH**

MRN:

Birthday: 1959-11-22

Visited on: 2022 Dec 15 13:40 (Age at visit: 63 years)

Phone:

Electronically signed by: GEORGE PALETTA, M.D. on 2022-12-22 09:06

ΔМ

# HPI

This the first visit for this 63 year old right hand dominant female. She presents for evaluation of a chief complaint of left shoulder pain, weakness and limited range of motion. This dates to an injury which occurred on May 12, 2022. On that date, she was shopping in a Bed, Bath and Beyond. She had a shopping cart with her. She was standing in one of the aisles or walkways. Apparently, an employee was pushing a cart that was filled with material and was piled high enough that the employee couldn't see her. She was hit directly from behind by this cart that was being pushed by the employee. It hit her directly in the back, injuring her neck, low back and left shoulder. She was knocked forward but did not fall to the floor. There was no loss of consciousness. She had immediate left shoulder pain in addition to her back and neck pain. She did not receive any medical attention that day, but believes the next day is when she first went to urgent care.

Ultimately, she was seen at Advanced Injury Care and underwent evaluation and treatment for both the neck and back problem as well as the shoulder problems. With respect to the neck, she underwent an MRI scan which showed evidence of previous anterior cervical fusion at C 5 - C 7. She had some disc pathology above and below the site effusion and she has had two injections of the cervical spine. She states the neck is doing "ok" at this point. There has not been any discussion of further surgical treatment for the neck.

With respect to the back, she was diagnosed with disc pathology, particularly at the L 4-5 level and has consulted with Dr. Lehman. The recommendation has been made for consideration for surgical treatment for the lumbar spine but not surgery has been scheduled.

Her third problem was that of the shoulder. She states that she has had difficulty with continued pain radiating down the arm. No associated numbness, tingling or paresthesias. She has difficulty with active motion and finds herself markedly limited with regard to the ability to forward flex or abduct the shoulder. She states, that prior to the incident of injury in May, she had no issues related to the shoulder. She has had no injections for the shoulder. The exception to that is her primary care physician did one injection. She states the injection performed by her primary care physician did not result in significant relief.

Past medical history, past surgical history, medications, allergies, review of systems, family history, and social history are as per the intake questionnaire, which I have personally reviewed.

# **EXAM**

Well-developed, well nourished, well appearing female in no acute distress. She is alert and oriented. She is pleasant and cooperative. Examination of the right shoulder is normal. Left shoulder reveals no asymmetry, muscle atrophy or deformity is noted. There is no tenderness at the AC joint, SC joint and bicipital groove. She has limited active range of motion. She complains of pain with attempts at forward flexion and can get to about 60 degrees. Abduction is to about 50 degrees. Passively, she can get to about 120, but she cannot maintain the arm in a position of abduction or forward flexion as she demonstrates a positive drop sign. With the arm to the side she externally rotates to about

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# ADVANCED INJURY CARE

8225 Clayton Road, Saint Louis, MO 631171107

**Surgical Consult Note** 

# CARLA COX SMITH

MRN:

Birthday: 1959-11-22

Visited on: 2022 Dec 15 13:40 (Age at visit: 63 years)

Phone:

Electronically signed by: GEORGE PALETTA, M.D. on 2022-12-22 09:06

AM

20. Internal and external rotation strength are 5/5. Again, she has marked weakness of the supraspinatus. With a positive drop test, it was difficult to assess true strength. No instability. Neurovascular status is intact.

# Results

RADIOLOGIC EXAM: X-rays available for review include a left shoulder series with AP of the glenohumeral joint in internal and external rotation, axillary, outlet and AP of the shoulder. These demonstrate AC joint degenerative changes which are age appropriate. The glenohumeral joint is well maintained.

MRI SCAN: MRI scan available for review is the study that was completed at Professional Imaging on October 4, 2022. I personally reviewed the study. It is a well done study of diagnostic quality. It demonstrates several abnormalities. There is an effusion as well as fluid in the subacromial space. Those are contiguous, consistent with a tear of the rotator cuff. There is a complete tear of the supraspinatus with minimal retraction. There is no atrophy of the supraspinatus muscle belly or fatty infiltration. The subscapularis is intact. The posterior cuff appears normal. There is irregularity of the labrum, but in my opinion, it does not appear consistent with a frank labral detachment or SLAP lesion. There are hypertrophic degenerative changes at the AC joint.

# **Assessment**

Full thickness rotator cuff tear, supraspinatus tendon, left shoulder.

# Plan

I had a long discussion with the patient regarding the diagnosis and condition affecting her left shoulder. She certainly has symptoms and physical exam findings consistent with a symptomatic rotator cuff tear. However, I explained to her that pain that comes all the way down the arm sometimes originates from the neck. She clearly has a neck issue and a shoulder issue. It is my opinion that physical therapy and injections of the shoulder are not likely to be beneficial and that she needs to consider arthroscopy with rotator cuff repair. I discussed with her the surgical procedure as well as the expected postop recovery and rehabilitation requirements. I explained to her that if she has the shoulder surgery done, it would likely be six weeks before she could consider the back surgery after the shoulder surgery. It might be worthwhile to consult with Dr. Lehman to find out how soon after the back surgery she could potentially have shoulder surgery so we could figure out which one to prioritize and potentially do first.

I do think it would be beneficial to get her into a little bit of physical therapy for the shoulder at this point to prevent her from developing adhesive capsulitis or frozen shoulder. However, I do not think that physical therapy will be the long term solution without surgical repair of the tear of the rotator cuff.

It is my opinion, based on the history provided to me by the patient and the absence of any prior history of left shoulder problems, that the injury incident of May 12, 2022, is a contributing or causative factor to her current left shoulder condition. Additionally, there

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is no evidence of a chronic long standing rotator cuff tear as there is no cuff retraction, supraspinatus or muscle belly atrophy or fatty infiltration of the supraspinatus.

George A. Paletta, Jr., M.D.

GAP:sdm

This report was dictated by#George A. Paletta, Jr., M.D.#and approved without proofreading/editing to expedite distribution.

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